

UNITED STATES DISTRICT COURT

WESTERN DISTRICT OF WISCONSIN

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GREGORY BOYER, as Administrator of the  
Estate of Christine Boyer, and on his own behalf,

Plaintiff,

vs.

Lead Case No. 20-CV-1123

ADVANCED CORRECTIONAL  
HEALTHCARE, INC., et al.,

Defendants.

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GREGORY BOYER, as Administrator of the  
Estate of Christine Boyer, and on his own behalf,

Plaintiff,

vs.

Case No. 22-CV-723

USA MEDICAL & PSYCHOLOGICAL  
STAFFING, et al.,

Defendants.

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ZOOM Deposition of BRUCE CHARASH, M.D.

Tuesday, January 28th, 2025

10:04 a.m. - 1:05 p.m.

appearing remotely from New York City, New York

Job No. 180758  
Stenographically Reported by Rosanne E. Pezze, RPR/CRR  
Certified Realtime Reporter

<p style="text-align: right;">Page 2</p> <p>1 Remote ZOOM Deposition of BRUCE CHARASH, 2 M.D., a witness in the above-entitled action, 3 taken at the instance of the Defendants, pursuant 4 to the Federal Rules of Civil Procedure, pursuant 5 to Notice, before Rosanne E. Pezze, RPR/CRR, 6 Certified Realtime Reporter and Notary Public, 7 State of Wisconsin, appearing remotely from New 8 York City, New York, on the 28th day of January, 9 2025, commencing at 10:04 a.m. and concluding at 10 1:05 p.m.</p> <p>11 12 <b>A P P E A R A N C E S:</b> 13 LOEVY &amp; LOEVY, by 14 Ms. Maria Makar 15 311 North Aberdeen Street, 3rd Floor 16 Chicago, Illinois 60607 17 312-243-5900 18 makar@loevy.com 19 Appeared via Zoom on behalf of Plaintiffs. 20 LEIB KNOTT GAYNOR, LLC, by 21 Mr. Douglas Knott 22 219 North Milwaukee Avenue, Suite 710 23 Milwaukee, Wisconsin 53202 24 414-276-2108 25 dknott@lkglaw.net Appeared via Zoom on behalf of Defendants ACH, Lisa Pisney and Amber Fennigkoh.</p>	<p style="text-align: right;">Page 4</p> <p>1 <b>I N D E X</b> 2 <b>EXAMINATION</b> <b>PAGE</b> 3 By Mr. Knott. . . . . 5, 108 4 By Mr. Jones. . . . . 84 5 By Mr. Casserly. . . . . 107 6 7 8 9 <b>E X H I B I T S</b> 10 <b>EXHIBIT NO.</b> <b>PAGE NUMBER</b> 11 Exhibit 117 Curriculum Vitae. . . . . 10 12 Exhibit 118 Bruce Charash, MD invoices. . . . 10 13 Exhibit 119 Deposition List of Bruce Charash, MD. 10 14 Exhibit 120 Trial List of Bruce Charash, MD. . 10 15 Exhibit 121 Gundersen ED Provider Notes (Bates GHS 1339). . . . . 54 16 17 Exhibit 122 Heart monitor strip (Bates GHS 1559). 55 18 19 (Original exhibits attached to Original transcript; 20 copies of exhibits are attached.) 21 22 <b>R E Q U E S T S</b> 23 24 (None.) 25</p>
<p style="text-align: right;">Page 3</p> <p>1 <b>A P P E A R A N C E S</b> (continued): 2 GERAGHTY, O'LOUGHLIN &amp; KENNEY, P.A., by 3 Mr. John B. Casserly 4 30 East 7th Street, Suite 2750 5 St. Paul, Minnesota 55101-1812 6 651-291-1177 7 jcasserly@goklawfirm.com 8 Appeared via Zoom on behalf of Defendants 9 USA Medical &amp; Psychological Staffing, 10 Jillian Bresnahan, Norman Johnson, Travis 11 Schamber and Wesley Harmston. 12 13 <b>HANSEN REYNOLDS, LLC, by</b> 14 Mr. Andrew A. Jones 15 301 North Broadway Street, Suite 400 16 Milwaukee, Wisconsin 53202 17 414-455-7676 18 19 Appeared via Zoom on behalf of Defendants 20 Monroe County Sheriff's Office, Stan 21 Hendrickson, Danielle Warren and Shasta 22 Parker. 23 <b>ALSO PRESENT:</b> Ms. Alecia Richards, Intern 24 25</p>	<p style="text-align: right;">Page 5</p> <p>1 <b>TRANSCRIPT OF PROCEEDINGS</b> 2 <b>BRUCE CHARASH, M.D.,</b> having been first 3 duly sworn remotely on oath, was examined and 4 testified as follows: 5 <b>E X A M I N A T I O N</b> 6 <b>BY MR. KNOTT:</b> 7 <b>Q</b> Sir, could you please state your full name for the 8 record. 9 <b>A</b> <b>Bruce Charash, C-H-A-R-A-S-H.</b> 10 <b>Q</b> And you are a medical doctor? 11 <b>A</b> <b>Yes.</b> 12 <b>Q</b> And what is your area of specialty? 13 <b>A</b> <b>Cardiology and internal medicine.</b> 14 <b>Q</b> And are you at your home today, Dr. Charash? 15 <b>A</b> <b>Yes. Pardon me. Yes.</b> 16 <b>Q</b> You've given depositions before? 17 <b>A</b> <b>Yes.</b> 18 <b>Q</b> You understand that I'm trying to find out what 19 opinions you may have to offer in this matter if 20 it were to go to trial? 21 <b>A</b> <b>Yes.</b> 22 <b>Q</b> And that I am questioning you based on a report 23 that we were given dated February 2, 2024. 24 Is that a report that you prepared? 25 <b>A</b> <b>Yes, it is.</b></p>

Page 6

1 Q And are those your final opinions in the matter?

2 A Yes, other than perhaps addressing any new defense

3 opinions if they're revealed that I haven't --

4 that have not yet been disclosed. But in terms of

5 my opinion in the case, yes, it's all there.

6 Q Okay. Let's go back.

7 Your curriculum vitae discloses an

8 address on 63rd Street. Is that your home or

9 professional address?

10 A Both.

11 Q So your home is your professional address?

12 A Yes.

13 Q You've given depositions in the past? I think I

14 asked you that, right?

15 A Correct.

16 Q And approximately how many depositions have you

17 given, Doctor?

18 A Well, I've been involved in these types of

19 litigations for 38 years, since 1987, and I've

20 probably been deposed 360-plus times in those same

21 years.

22 Q 360. Do you have some kind of count, or is that

23 an estimate based on a certain number per year?

24 A Well, it's an estimate based on -- it's an

25 estimate I've kept over the years, not a count.

Page 7

1 I'd say I average maybe 10 a year to 11 a year, so

2 maybe it's 370. I don't know the exact number.

3 You know, in the first few years I did very few

4 testimony.

5 Q Did you testify in the past that you've given more

6 than 900 depositions?

7 A No. I have testified multiple times that I have,

8 A, reviewed around 1,000 to 1,100 cases in 38

9 years, or back then 37 years.

10 Then I've also testified that I

11 have appeared in court on average seven times a

12 year in trial for 38 years, and have appeared in

13 deposition around 10 to 11 times a year.

14 Then I've testified, and people

15 have asked me if I add my depositions and trials,

16 does that reach a number like 6- or 700, and I

17 said yeah, if you add up all the trials and

18 depositions, even though there's overlap. But

19 I've never done 900 depositions and I've never

20 testified to that. If so, it's transcribed wrong,

21 because it's clear I'm very consistent in my

22 replies.

23 Q Okay. So have you ruled -- reviewed anything

24 since the time of your report from February of

25 2024?

Page 8

1 A With regard to Christine Boyer and the case

2 involving her?

3 Q Of course.

4 A Yes, I reviewed the defense reports, multiple

5 defense reports.

6 Q And can you tell me the names of the expert

7 reports that you've reviewed so that we know.

8 There's --

9 A I'd have to look it up. One was John Wolff,

10 Dr. Wolff. I don't remember his first name.

11 Sorry. Dr. Wolff. I reviewed the report of

12 Kimberly Pearson, who's a nurse, I believe.

13 Dr. Murray Young, a New York doctor. Matthew

14 Wolff is his name. Sorry. Matthew Wolff. I

15 think there was another report, but I'm not sure.

16 Let me look. I'm going to have to look it up, but

17 those for sure.

18 Q Okay. Do you have Dr. Wolff's report in front of

19 you, sir?

20 A I do.

21 Q And you have Ms. Pearson and Dr. Young's reports

22 in front of you as well?

23 A I do not.

24 Q Did you make any notes or do any highlighting of

25 Dr. Wolff's report?

Page 9

1 A No.

2 Q You met with Ms. Makar before the deposition?

3 A Yesterday we had a video chat.

4 Q Can you tell me approximately how long that chat

5 was?

6 A Less than an hour, but probably close to an hour.

7 Q Were there any other people on the chat?

8 A No.

9 Q Did you ask to see anything during the chat?

10 A No.

11 Q Were you shown anything during the chat?

12 A No.

13 Q You reviewed the duces tecum request for documents

14 that was sent to you for the deposition today?

15 A Yes.

16 Q And one of the things that it asked for is whether

17 you have any notes from your work on the matter.

18 Do you have any notes?

19 A No, I don't. My report are my notes.

20 Q You have no notes other than the final report?

21 A Correct.

22 Q Dr. Charash, when you were preparing your report,

23 did you look up or reference any literature in

24 order to confirm your opinions?

25 A No.

3 (Pages 6 to 9)

<p style="text-align: right;">Page 10</p> <p>1 Q And do you review a case, when you review cases,</p> <p>2 do you review them via PDF, or do you review them</p> <p>3 on paper?</p> <p>4 A PDF.</p> <p>5 Q And does your process include selecting documents</p> <p>6 and putting them in a separate file if they're</p> <p>7 particularly important or highlighting them?</p> <p>8 A No.</p> <p>9 Q Do you keep a separate note where you would write</p> <p>10 down Bates numbers that are particularly</p> <p>11 important?</p> <p>12 A No.</p> <p>13 Q So I'm going to mark your curriculum vitae as</p> <p>14 Exhibit 117. I'll mark, when we take a break,</p> <p>15 I'll mark your -- the invoices that we were</p> <p>16 provided as 118, your deposition list 119, your</p> <p>17 trial testimony 120.</p> <p>18 So we were provided a list of your</p> <p>19 testimony, two lists of your testimony in response</p> <p>20 to the duces tecum or in your disclosure.</p> <p>21 Do you maintain a list of the cases</p> <p>22 in which you've testified?</p> <p>23 A I just keep a list of the last four years.</p> <p>24 Q And do you have the list that was provided in this</p> <p>25 case?</p>	<p style="text-align: right;">Page 12</p> <p>1 you know?</p> <p>2 A Other than this matter, I don't remember. There's</p> <p>3 maybe one other, but I'm not sure, actually.</p> <p>4 Q What is -- what clicks in your mind that you think</p> <p>5 you may have been retained in one other?</p> <p>6 A I'm not sure. For me, I have a very powerful</p> <p>7 passive memory in the sense that, for example, you</p> <p>8 could read me these case names; I won't remember</p> <p>9 anything about them, even if it was a month ago.</p> <p>10 But if I'm given a small trigger of information,</p> <p>11 I'll remember every detail of the case.</p> <p>12 So the name, the Loevy firm's name</p> <p>13 is familiar to me, and I'm not sure if it's just</p> <p>14 because of this case I've been involved with, or</p> <p>15 one other. But if I was given a small piece of</p> <p>16 information, I would actively remember. So I</p> <p>17 don't know.</p> <p>18 Q Well, your list includes a single word under the</p> <p>19 case name. Is that the plaintiff or the</p> <p>20 defendant, or do you know?</p> <p>21 A Always the plaintiff. It's always by plaintiff,</p> <p>22 because I figure that's the easiest way to track</p> <p>23 it down.</p> <p>24 Q Have you ever testified in federal court, sir?</p> <p>25 A A long, long time ago.</p>
<p style="text-align: right;">Page 11</p> <p>1 A Yes. I don't have it printed, but it's in my -- I</p> <p>2 can access it.</p> <p>3 Q Let me see if I can access it.</p> <p>4 A What happened?</p> <p>5 Q So I'm --</p> <p>6 A Oh, okay. Good.</p> <p>7 Q -- I'm sharing with you what's been marked as</p> <p>8 Exhibit 119. It's a deposition list.</p> <p>9 Was this the list that you</p> <p>10 referenced of your deposition testimony?</p> <p>11 A Yes.</p> <p>12 Q And it doesn't include any testimony in 2021. Did</p> <p>13 you testify at all in 2021?</p> <p>14 A Virtually no. It was COVID. I have one</p> <p>15 deposition in January and that was it.</p> <p>16 Q Okay. So I counted, and you testified 17 times in</p> <p>17 2022. You didn't testify at all in 2021 --</p> <p>18 A Correct.</p> <p>19 Q -- except for that one case during COVID?</p> <p>20 A Yeah, I don't think there was any more than that.</p> <p>21 I'm not sure.</p> <p>22 Q Have you ever reviewed a case involving plaintiffs</p> <p>23 or defendants in the state of Wisconsin?</p> <p>24 A Not that I'm aware of, no.</p> <p>25 Q Have you ever been retained by the Loevy firm, if</p>	<p style="text-align: right;">Page 13</p> <p>1 Q How long?</p> <p>2 A Five, ten years, I think. I'm not sure. I don't</p> <p>3 really remember exactly when.</p> <p>4 Q So we can --</p> <p>5 A I think -- this is probably my only case with the</p> <p>6 Loevy firm, but I'm not 100 percent sure.</p> <p>7 Q So we can assume that any testimony on this list</p> <p>8 is in state court; is that correct?</p> <p>9 MS. MAKAR: Objection. Form.</p> <p>10 A These would not be federal cases.</p> <p>11 BY MR. KNOTT:</p> <p>12 Q And are the -- there's a single word for the most</p> <p>13 part under the column "Lawyer." Is that the</p> <p>14 individual lawyer that you worked with on the</p> <p>15 case, or is it a firm?</p> <p>16 A It's the lead name of the letterhead of the firm.</p> <p>17 Q It looks like you've worked with two lawyers in</p> <p>18 Illinois, Taxman and Loggins. There's one more.</p> <p>19 Meyer Kiss, I guess.</p> <p>20 Do you know what -- do you have a</p> <p>21 recollection of any matters in which you testified</p> <p>22 for the Loggins firm or Ms. Loggins or</p> <p>23 Mr. Loggins?</p> <p>24 A I won't remember any details. I need something to</p> <p>25 trigger that memory.</p>

<p style="text-align: right;">Page 14</p> <p>1 Q As you look at this list, do you think that any of</p> <p>2 these cases involved congestive heart failure? Do</p> <p>3 you have any --</p> <p>4 A <b>If you're saying generically, congestive heart</b></p> <p>5 <b>failure may have been a role in a number of cases.</b></p> <p>6 <b>I don't know if they did. But, you know, I</b></p> <p>7 <b>wouldn't characterize this case as simple heart</b></p> <p>8 <b>failure. But that said, I may have. But I don't</b></p> <p>9 <b>think I've ever had a case, at least in recent</b></p> <p>10 <b>memory, that's similar to this case. But I don't</b></p> <p>11 <b>know.</b></p> <p>12 <b>Are we waiting on something? I'm</b></p> <p>13 <b>confused.</b></p> <p>14 Q Yeah, I said bear with me, please. I'm trying</p> <p>15 to --</p> <p>16 A <b>Oh, sorry. I couldn't hear that. Remember, with</b></p> <p>17 <b>this cold, if I -- I'm not 100 percent sure I</b></p> <p>18 <b>didn't miss anything.</b></p> <p>19 Q And I'm putting on the screen now Exhibit 120,</p> <p>20 which is a list of trial testimony that we were</p> <p>21 provided.</p> <p>22 Do you recognize that?</p> <p>23 A <b>I do.</b></p> <p>24 Q And these are the matters in which you went to</p> <p>25 court and actually testified in a case?</p>	<p style="text-align: right;">Page 16</p> <p>1 approximately 40 states; is that correct?</p> <p>2 A <b>Yes.</b></p> <p>3 Q And, Doctor, do you continue to see patients at</p> <p>4 this time?</p> <p>5 A <b>Yes.</b></p> <p>6 Q And tell me about your current professional</p> <p>7 responsibilities.</p> <p>8 A <b>Well, I see patients. I'm the cardiologist for</b></p> <p>9 <b>half my practice. For 25 percent they came to me</b></p> <p>10 <b>for cardiology but then asked if I would also be</b></p> <p>11 <b>their primary care doctor in addition to</b></p> <p>12 <b>cardiology. And then another 25 percent came to</b></p> <p>13 <b>me just for primary care, but over time, at least</b></p> <p>14 <b>half of them have developed some form of cardiac</b></p> <p>15 <b>issue or concern.</b></p> <p>16 <b>I'm a noninvasive cardiologist. I</b></p> <p>17 <b>do echocardiograms. I used to do stress testing</b></p> <p>18 <b>in my office. No more. But I do echocardiograms</b></p> <p>19 <b>and physical exams. I'm an attending at Lenox</b></p> <p>20 <b>Hill Hospital in New York. And that's my</b></p> <p>21 <b>practice. 9:00 to 5:00 office hours. About</b></p> <p>22 <b>85 percent of my time is in the office and about</b></p> <p>23 <b>15, 10 to 15 percent of the time is in the</b></p> <p>24 <b>hospital.</b></p> <p>25 Q And do you have any employees in your practice</p>
<p style="text-align: right;">Page 15</p> <p>1 A <b>Yes.</b></p> <p>2 Q And it looks like you testified in the last four</p> <p>3 years in a single matter in the state of Illinois;</p> <p>4 is that correct?</p> <p>5 A <b>Yes.</b></p> <p>6 Q Do you remember where that was?</p> <p>7 A <b>No.</b></p> <p>8 Q And did you go to court at any time before October</p> <p>9 of 2021 --</p> <p>10 A <b>No.</b></p> <p>11 Q -- in the calendar year 2021?</p> <p>12 A <b>No. That was -- again, I don't think so. That's</b></p> <p>13 <b>at the tail end of COVID, but I'm not sure.</b></p> <p>14 Q I read in previous testimony that you believed</p> <p>15 that you had testified in matters pending in about</p> <p>16 40 states. Is that accurate?</p> <p>17 A <b>No. I reviewed cases from lawyers in</b></p> <p>18 <b>approximately 40 states. I've only testified in</b></p> <p>19 <b>maybe 15 of them, between depo and trial, and</b></p> <p>20 <b>probably only eight or nine in trial. Most of the</b></p> <p>21 <b>cases are on the northeast, from the east coast.</b></p> <p>22 <b>East coast. But I've not testified in most of</b></p> <p>23 <b>those states.</b></p> <p>24 Q So it's accurate to say that you've -- you</p> <p>25 reviewed matters from lawyers based in</p>	<p style="text-align: right;">Page 17</p> <p>1 other than yourself?</p> <p>2 A <b>No, not anymore.</b></p> <p>3 Q And you have privileges at Lenox Hill?</p> <p>4 A <b>Yes.</b></p> <p>5 Q You're not listed on the Lenox Hill website.</p> <p>6 A <b>Correct.</b></p> <p>7 Q Do you have an understanding why not?</p> <p>8 A <b>It's voluntary, and I'm not looking to expand my</b></p> <p>9 <b>practice. That's where people can find doctors.</b></p> <p>10 <b>It's only there to give people access to</b></p> <p>11 <b>practices, their information, match the insurance.</b></p> <p>12 <b>But I'm not open to new patients unless it's a</b></p> <p>13 <b>case by case through referral, but I'm not letting</b></p> <p>14 <b>my name be out in the public anymore.</b></p> <p>15 Q Are most of the physicians at Lenox Hill employed</p> <p>16 by a single entity?</p> <p>17 A <b>No. The overwhelming majority are private</b></p> <p>18 <b>practice, and they're affiliated at Lenox Hill.</b></p> <p>19 <b>But there is a -- they have hospitalists now.</b></p> <p>20 <b>Things have changed. So they have hospitalists in</b></p> <p>21 <b>the hospital. But most cardiologists, most</b></p> <p>22 <b>primary care doctors don't get -- don't get paid</b></p> <p>23 <b>by the hospital or any medical school.</b></p> <p>24 Q And can you tell me how many patients you see a</p> <p>25 week on average?</p>

Page 18

1 **A A week on average. Between 40 and 60.**  
 2 Q And do you -- I know that it's a big commitment to  
 3 be on the list of providers for health insurers.  
 4 Are you authorized to provide services and bill to  
 5 any health insurance companies?  
 6 MS. MAKAR: Objection. Form.  
 7 **A No, I am not.**  
 8 BY MR. KNOTT:  
 9 Q So all of your patients are private pay?  
 10 **A Well, half are. Half my patients pay me an annual**  
 11 **fee based on how much they're going to need me.**  
 12 **People call it concierge practice. But the other**  
 13 **half of my patients are military, Medicare, other**  
 14 **people who I don't charge at all. The wealthier**  
 15 **half of my practice pays for the other half of my**  
 16 **practice, and everyone gets my cell phone number**  
 17 **and everyone can contact me when they need to.**  
 18 **And I do house calls for everyone.**  
 19 Q I'm sorry that I'm wading into something I don't  
 20 understand very well, but do you bill Medicare?  
 21 **A No. My patients pay a flat fee to have me look**  
 22 **after them.**  
 23 Q Okay. So you're saying that half your patients,  
 24 and I know it's approximate, are private pay and  
 25 that their compensation to you covers the rest of

Page 19

1 the patients that you provide services to?  
 2 **A Correct.**  
 3 Q I want to go back to your testimonial history just  
 4 for a second here.  
 5 Doctor, among the cases in which  
 6 you testified at trial, do you know the  
 7 approximate percentage where you were retained by  
 8 the plaintiff?  
 9 **A I do. Of cases in which I've been retained,**  
 10 **85 percent have been for plaintiff cases and**  
 11 **15 percent for defense. But when it comes to**  
 12 **testifying, about 95 to 96 percent are for**  
 13 **plaintiff and 4 to 5 percent are for defense.**  
 14 Q Do you have any idea why that might be, Doctor,  
 15 that that's sort of tilted that way?  
 16 MS. MAKAR: Objection. Form.  
 17 **A I absolutely do have an idea why. 15 percent of**  
 18 **my cases come from defense firms. Now, I reject a**  
 19 **lot of plaintiff's cases just on a phone call**  
 20 **saying -- if someone said a patient had a stroke**  
 21 **during a catheterization, and I tell them that's a**  
 22 **normal -- a well-known side effect, I won't review**  
 23 **the case. If I don't think there's anything**  
 24 **there, I'm not going to waste anyone's time or**  
 25 **money.**

Page 20

1 **But defense lawyers have no choice**  
 2 **but to analyze their case, whether they can defend**  
 3 **a doctor legitimately or not.**  
 4 **So about 15 percent of the defense**  
 5 **cases that I review, I find that I cannot easily**  
 6 **defend the doctor, but the defense lawyers still**  
 7 **want me to review it and have me at least kind of**  
 8 **mitigate the damages or whatever can be done.**  
 9 **Those cases I'm never going to testify in. So**  
 10 **15 percent of my cases are defense cases.**  
 11 **About -- only 7 percent of them absolute -- of all**  
 12 **my cases, I'm willing to testify on the defense.**  
 13 **And of those, about half resolve before I'm even**  
 14 **asked to testify, whereas, very few plaintiff**  
 15 **cases resolve that way. That's why it's a much**  
 16 **smaller percentage of testifying in defense cases.**  
 17 BY MR. KNOTT:  
 18 Q Doctor, I put your trial list back up on the  
 19 screen, the list of your trial testimony in the  
 20 last four years.  
 21 And I'll scroll through it so you  
 22 can see it all. But do any of those stand out as  
 23 a case in which you testified for a defendant at  
 24 trial?  
 25 **A Actually, the first one on the list, Rakhit, I**

Page 21

1 **was -- was a doctor I was defending. But the rest**  
 2 **I'm unsure. It just stood out because it was a**  
 3 **lawyer named Margolis and I know he was defending**  
 4 **them. But I wouldn't be able to tell you which**  
 5 **other ones were defense.**  
 6 Q Do you know Margolis' first name?  
 7 **A Not anymore. I could probably dig it out, but I**  
 8 **don't remember it.**  
 9 Q Bear with me. And I put up on the screen once  
 10 again your deposition testimony list, which is  
 11 Exhibit 119.  
 12 Looking at that, do you recognize  
 13 any of those cases as being a case in which you  
 14 testified on behalf of the defendant?  
 15 **A There's too many. I don't know. I mean, I would**  
 16 **have to try and dig out -- I don't remember, so I**  
 17 **don't know.**  
 18 Q Okay. I'm scrolling through them, and your answer  
 19 is you don't know?  
 20 **A Correct.**  
 21 MS. MAKAR: Objection.  
 22 **A I just don't know.**  
 23 BY MR. KNOTT:  
 24 Q Fair enough.  
 25 Doctor, do you know if you've ever

6 (Pages 18 to 21)



Page 22

1 testified in a matter involving a detainee in a  
 2 jail or prison?  
 3 **A I have. I have a number of them in New York**  
 4 **State. I've probably testified in deposition in**  
 5 **about three or four cases, but I don't think I've**  
 6 **ever been called to court, at least not as of now,**  
 7 **except for this case.**  
 8 Q And in the three or four cases that you were asked  
 9 to review, at least, were all of those in the  
 10 state of New York?  
 11 **A Yes, I believe so.**  
 12 Q And do you know if those involved claims that  
 13 civil rights were infringed upon?  
 14 **A I believe some of them at least were, yes.**  
 15 Q And were you instructed or do you feel  
 16 knowledgeable of the Constitutional standard by  
 17 which a healthcare provider is judged in a civil  
 18 rights case?  
 19 **A No. I had nothing to do with that aspect of the**  
 20 **case, determining civil rights violations. I only**  
 21 **talked about the medicine.**  
 22 Q And my understanding is that you'll be called to  
 23 testify in this matter as to issues of causation  
 24 only; is that fair?  
 25 MS. MAKAR: Objection. Form.

Page 23

1 **A Yes. My opinions in my report were all causation**  
 2 **opinions, and I have no intention of testifying**  
 3 **about standard of care.**  
 4 BY MR. KNOTT:  
 5 Q And I appreciate that answer, and I appreciate  
 6 that you understand the difference between  
 7 standard of care and causation, but let me just  
 8 ask these questions briefly and we'll get through  
 9 this.  
 10 You've never practiced in a  
 11 correctional facility, correct?  
 12 **A Correct.**  
 13 Q You've never held a contract to provide healthcare  
 14 services at a correctional facility, correct?  
 15 **A Correct.**  
 16 Q You're not trained as a nurse or a nurse  
 17 practitioner, correct?  
 18 **A Correct.**  
 19 Q And is it fair to say you don't have any opinions  
 20 on the care provided to -- strike that.  
 21 You don't have any opinions on the  
 22 adequacy of county or Advanced Correctional  
 23 Healthcare policies and procedures, correct?  
 24 MS. MAKAR: Objection to form.  
 25 **A I will not be commenting on those things.**

Page 24

1 BY MR. KNOTT:  
 2 Q And, Doctor, you may have noted from your review  
 3 of Dr. Young's report that there are several other  
 4 inmates whose care has been put at issue in this  
 5 case.  
 6 Is it fair to say that you don't  
 7 have any opinion about the care provided by  
 8 Advanced Correctional or Monroe County Jail to  
 9 detainees other than Christine Boyer?  
 10 **A Correct.**  
 11 MS. MAKAR: Objection. Form.  
 12 **A Yes, I have no opinions.**  
 13 BY MR. KNOTT:  
 14 Q Doctor, do you know whether your current earnings  
 15 in medical-legal cases exceed those earnings in  
 16 your professional practice?  
 17 **A They do not. My earnings medical-legally have run**  
 18 **averaging 15 to 20 percent. There were a handful**  
 19 **of years in the early 2000s where it was up to**  
 20 **25 percent, but it's averaging around 20 percent**  
 21 **of my income.**  
 22 Q Thank you.  
 23 Doctor, I'm trying to find a  
 24 document and I keep making the same mistake every  
 25 time I do this, so I apologize.

Page 25

1 **A By the way, I'm sorry, Mr. Knott. This wasn't**  
 2 **clear when we started this deposition, but who is**  
 3 **your client in this case?**  
 4 Q I apologize. I should have introduced myself.  
 5 Yeah, I represent Nurse Practitioner Pisney, Nurse  
 6 Fennigkoh, and Advanced Correctional Healthcare,  
 7 which is a private correctional healthcare  
 8 provider.  
 9 **A Okay. Thank you. Just wasn't sure.**  
 10 Q Okay. You're welcome.  
 11 And, sir, I put up on the screen  
 12 your curriculum vitae, which was marked as  
 13 Exhibit 117. Any significant changes or updates  
 14 to this in the last couple of years? I guess  
 15 you've been involved in the case since 2022.  
 16 Maybe it could be that old.  
 17 **A Can you just scroll a little further down? Keep**  
 18 **going. No, this is updated. This is -- it's**  
 19 **current. Nothing's changed in the last couple of**  
 20 **years.**  
 21 Q Okay. You currently don't have any academic  
 22 appointments, correct?  
 23 **A That I'm aware of. That's the weird part. Lenox**  
 24 **Hill joined a giant network called Northwell,**  
 25 **which is now the biggest medical entity in New**

7 (Pages 22 to 25)

Page 26

1 York State, and they became affiliated with a new  
2 medical school on Long Island named Hofstra.  
3 Pretty much anyone who's a voluntary doctor at a  
4 hospital is given the minimum credential of  
5 clinical assistant professor of medicine.

6 But I've never heard back from  
7 them, and it's been kind of weird, so I'm trying  
8 to find out. But I can't name -- I can't  
9 guarantee I have it. I teach medical students  
10 regularly from Hofstra, and I give lectures to all  
11 the doctors in training at Lenox Hill, but I'm not  
12 100 percent sure if my title is formalized. I  
13 don't know.

14 Q You are not assigned to represent any residents at  
15 this time. Fair?

16 A No private doctor is assigned residents, no.

17 Q In what context do you supervise residents, sir?

18 A There are a few. The first is, every time I go to  
19 the hospital and I see one of my patients, I pull  
20 together the clinical team which involves medical  
21 students, interns, residents and sometimes  
22 cardiology fellows. And I not only go over the  
23 instructions for my patient, but I actually go  
24 over the medicine and teach them things on  
25 physical exam or on clinical and academic interest

Page 27

1 of the case.

2 Secondly, about three times a year  
3 I give big lectures to everyone on staff, all the  
4 doctors in training from students to fellows, on  
5 acute coronary issues like chest pain in the ER.  
6 I used to run the cardiac arrest team, so I give a  
7 lecture about new advances in cardiac arrest. And  
8 then a couple of -- several times a year I will be  
9 called spontaneously by the residents the night  
10 before to come in the next day at 6:00 to have a  
11 conference with the residents who are on call the  
12 night before, called resident report, where they  
13 bring up what they think is the more challenging  
14 admissions they want to discuss.

15 And finally, one month out of every  
16 two years, because there's so many of us, I'm the  
17 cardiology consult attending for the month where I  
18 go over the service patients with the clinical  
19 care team doctors in training. So those are the  
20 different venues by which I teach.

21 Q Okay. You have no affiliation with this Northwell  
22 entity, correct?

23 A With what?

24 Q You have no affiliation with the Northwell entity?

25 A No, no. I'm affiliated with Northwell because I'm

Page 28

1 at Lenox Hill. It's whether I have an affiliation  
2 with Hofstra Medical School. The academic  
3 appointment would be Hofstra. Lenox Hill is  
4 Northwell.

5 Q Okay. Got it. So you're on some sort of coverage  
6 schedule at Lenox Hill; is that fair?

7 A No. I don't know what you mean by that.

8 Q Well --

9 A I don't --

10 Q -- you don't cover -- then let me try to clarify.

11 You do not see patients at Lenox  
12 Hill other than your own, the patients that you  
13 admit; is that correct?

14 A Yes, other than if I'm the consult attending,  
15 which comes once every couple of years. But yes,  
16 I only see my patients.

17 Q Okay. And that was my question. Something comes  
18 up once every couple of years. What is that?

19 A It's the rotation for who's the cardiology  
20 attending of the month for what's called the  
21 cardiology consult service for patients who don't  
22 have private doctors that rely on the consult  
23 service.

24 Q So once every couple of years you provide coverage  
25 on call for Lenox Hill?

Page 29

1 A No, it's -- the consult service is for patients  
2 who don't have private doctors, and there's a  
3 fellow and residents covering them, on call  
4 covering them at night.

5 Q How is what you're saying different than what I'm  
6 saying? I don't understand.

7 A Well, it's not like I'm on call in general for the  
8 hospital. I'm just seeing what we call the  
9 consult service. I don't know how else to clarify  
10 that. I'm really sorry. I'm not getting where  
11 we're not communicating. I apologize.

12 Q Yeah. Well, I wouldn't expect that any physician  
13 would be generally on call for all issues. But --  
14 so you are on a call rotation for the cardiology  
15 services at Lenox Hill; is that fair?

16 MS. MAKAR: Objection. Form.

17 A I wouldn't phrase it that way. Because there are  
18 a lot of cardiologists, I get told that on a given  
19 month I will be the consult attending. Usually  
20 every year, but there are too many cardiologists,  
21 so we all rotate. So I will say -- you know,  
22 April 2026 I'll be the consult attending.

23 I don't know what -- what you're  
24 saying doesn't seem to register the same to me,  
25 but I think I'm being very clear about what that

8 (Pages 26 to 29)



<p style="text-align: right;">Page 30</p> <p>1 is.</p> <p>2 BY MR. KNOTT:</p> <p>3 Q And when you're on that service, do you see</p> <p>4 patients in the ER?</p> <p>5 A Sometimes, but sometimes -- I see my patients in</p> <p>6 the ER. The consult service usually gets called</p> <p>7 after the emergency room, but sometimes they're</p> <p>8 called through the emergency room. It's not very</p> <p>9 common, but it can happen.</p> <p>10 Q And when was the last time you provided a lecture</p> <p>11 in an academic setting?</p> <p>12 A Academic setting. Well, again, these are lecture</p> <p>13 hall, you know, resident lectures. I think it was</p> <p>14 last June.</p> <p>15 Q So is that June of 2024?</p> <p>16 A Yes, June of 2024. I haven't given a lecture this</p> <p>17 year yet.</p> <p>18 Q And do you prepare slides for your discussions?</p> <p>19 A No, I actually don't. I like to use a whiteboard</p> <p>20 to keep them engaged, and then it's mostly</p> <p>21 didactics.</p> <p>22 Q And in that context, what was your -- how did you</p> <p>23 get connected to provide that lecture?</p> <p>24 A Well, for 20 years I was the chief of the cardiac</p> <p>25 care unit at Lenox Hill and I started giving those</p>	<p style="text-align: right;">Page 32</p> <p>1 A Yes.</p> <p>2 Q What is it?</p> <p>3 A Doc2Dock.com. Dot org, I mean.</p> <p>4 Q So it's the -- the organization name that I've</p> <p>5 highlighted there on the screen, which is capital</p> <p>6 D-O-C, number 2, capital D-O-C-K --</p> <p>7 A Dot org.</p> <p>8 Q Dot org?</p> <p>9 A Yes.</p> <p>10 Q Your CV includes some publications and abstracts.</p> <p>11 Are there any publications that you</p> <p>12 consider relevant to this matter?</p> <p>13 A I haven't published in over 30 years, and none of</p> <p>14 them are relevant.</p> <p>15 Q And you published a book called "Heart Myths."</p> <p>16 What was the -- what was your angle there, Doctor?</p> <p>17 What were the heart myths?</p> <p>18 A That there are a lot of -- that when we digest</p> <p>19 publicly health advice, we're often given an</p> <p>20 overgeneralized view and sometimes gloss over</p> <p>21 data. For example, I considered it a myth that</p> <p>22 salt is bad for everyone. There are certain</p> <p>23 people with hypertension that will get worse if</p> <p>24 they avoid salt; that's 20 percent of them. Or</p> <p>25 that a leaky valve means something's leaking in</p>
<p style="text-align: right;">Page 31</p> <p>1 lectures when I was chief of the unit. I was</p> <p>2 chief -- well, less than 20 years, from 1991 to</p> <p>3 2006.</p> <p>4 Then when I went into private</p> <p>5 practice, they still had me come in and give talks</p> <p>6 to the residents about coronary management. I was</p> <p>7 also the director of the Chest Pain Center in the</p> <p>8 emergency room, and I was the chief of the Cardiac</p> <p>9 Arrest Team for the hospital. So I had areas of</p> <p>10 interest and I'd give talks.</p> <p>11 Q Yeah, and I apologize, I'm trying to find my way</p> <p>12 through here.</p> <p>13 But the people that you spoke to</p> <p>14 are residents; they are not medical students of</p> <p>15 Hofstra?</p> <p>16 A No, they are. They include medical students at</p> <p>17 Hofstra that are rotating at Lenox Hill.</p> <p>18 Q All right. So this Doc2Dock, is that still</p> <p>19 active?</p> <p>20 A Yes, but I turned over day-to-day operations to a</p> <p>21 partner organization, because maintaining a</p> <p>22 warehouse in New York was becoming too expensive.</p> <p>23 But my infrastructure and the methodology still is</p> <p>24 running.</p> <p>25 Q Does it have a website?</p>	<p style="text-align: right;">Page 33</p> <p>1 your heart.</p> <p>2 So some of it's a bunch of</p> <p>3 misunderstandings, but in the book I explain how</p> <p>4 the heart works and how pathology occurs, and I</p> <p>5 explore misconceptions people have.</p> <p>6 Q You state in your report that you reviewed CCTV</p> <p>7 footage from December 23, 2019.</p> <p>8 Have you reviewed that recently?</p> <p>9 A I had reviewed it early when I got the case, but I</p> <p>10 have not relooked at it in a long time.</p> <p>11 Q As you sit here today, is there any -- do you have</p> <p>12 any recollection of the video and anything that</p> <p>13 would be pertinent? Can you identify anything</p> <p>14 that would be pertinent from that video to your</p> <p>15 opinions?</p> <p>16 A No. Just what's in my report, the timeline of</p> <p>17 events.</p> <p>18 Q You describe in your report at Page 3 what you saw</p> <p>19 on the video as "what appeared to be a seizure."</p> <p>20 Is there anything about the manner</p> <p>21 in which Ms. Boyer collapsed that tells you --</p> <p>22 that gives you clinical information?</p> <p>23 A No. Just that she had a seizure, which Dr. Wolff</p> <p>24 and I appear to agree that it was a seizure from</p> <p>25 oxygen deprivation to her brain from some sort of</p>

Page 34

1 **arrhythmia.**  
 2 Q Do you agree that in that video footage that prior  
 3 to the seizure she does not appear to be  
 4 experiencing any distress or discomfort?  
 5 MS. MAKAR: Objection. Form.  
 6 Foundation.  
 7 A Well, there's no way to know if she's in distress  
 8 or discomfort. She was not showing outward  
 9 indicators of duress, but that doesn't mean she  
 10 wasn't in pain. Lots of people have pain and  
 11 don't show it. So I wouldn't draw too much of a  
 12 conclusion other than she was not in apparent  
 13 acute distress. But it doesn't mean she wasn't in  
 14 pain or in any form of -- it doesn't mean she was  
 15 comfortable breathing; it just means she didn't  
 16 look acutely distressed.  
 17 BY MR. KNOTT:  
 18 Q Have you accepted as true the correctional  
 19 officer's testimony that she had a single report  
 20 of chest pain around 7:30 p.m.?  
 21 A Well, first of all, if you look at the note, it's  
 22 not a single episode. It says here that her chest  
 23 pain has been on and off all day long, so that is  
 24 no longer a single episode.  
 25 What we don't know is, which you

Page 35

1 have purported, when did it go away completely.  
 2 If it was episodic, it means it reoccurs. So she  
 3 could go for any period of time, in theory, and  
 4 have no pain and then it could reoccur again. So  
 5 she reported an episodic recurrent phenomenon that  
 6 was occurring all day long. It was not one  
 7 episode that went away. It was a recurrent  
 8 episode. And we don't know, there was no specific  
 9 history taken of her symptoms.  
 10 Q So it was recurrent prior to that report.  
 11 Do you accept the testimony that it  
 12 then resolved around 8:00 p.m. and was not  
 13 reported again that evening?  
 14 MS. MAKAR: Objection. Form.  
 15 A The sentence has to be broken down to whether  
 16 anyone asked her or whether she volunteered it.  
 17 There's three possibilities. If somebody asked  
 18 her, are you having pain, she said no. And were  
 19 they doing that throughout the night. Or did she  
 20 report pain. Or if no one asked her, could she be  
 21 having recurrent symptoms. But since she's  
 22 already been evaluated, it's conceivable she  
 23 doesn't continue to mention it.  
 24 All we know is that after  
 25 8:00-something, no one is documenting pain, but it

Page 36

1 doesn't exclude her from having pain. Just  
 2 there's no evidence that she was in pain. So if  
 3 she had episodic pain all day long, it could have  
 4 just managed, but I think that we don't have any  
 5 evidence.  
 6 But I don't want to get into  
 7 standard of care here, because that's kind of  
 8 getting close to that. I'm only giving you a  
 9 causation opinion.  
 10 BY MR. KNOTT:  
 11 Q I understand that. And so, we agree there's no  
 12 evidence that she reported pain after  
 13 approximately 8:00 p.m.?  
 14 A There's no evidence that -- there's no  
 15 documentation for having chest pain after  
 16 8:00 p.m. That's all we can say.  
 17 Q Doctor, I'm looking at your report at Page 2 under  
 18 Factual Background. There is -- the first two  
 19 paragraphs.  
 20 Is that what you believe to be the  
 21 relevant past medical history?  
 22 A Yes. I mean, I didn't go into the details of her  
 23 having recurrent abdominal pelvic surgeries,  
 24 because those were all consequences of her cancer,  
 25 and none of them are life-threatening injuries,

Page 37

1 just major quality of life issues for her. But  
 2 yeah, these are the major issues.  
 3 Q I'm sorry. I didn't hear you there.  
 4 A These are the major issues. These are the major  
 5 medical issues.  
 6 Q But I didn't hear your response, and you said  
 7 something about quality of life?  
 8 A Oh. She had -- she was -- obviously had suffering  
 9 of abdominal pain and had multiple procedures and  
 10 surgeries on her abdomen and pelvis because of the  
 11 cancer she experienced when she was young. But  
 12 that was not a life-threatening issue; that's a  
 13 quality of life issue.  
 14 Q Okay. And you disagree with her report that she  
 15 had less than one year to live?  
 16 MS. MAKAR: Objection.  
 17 A Well, first of all, it sounds like she was  
 18 intoxicated when she came in. But there's no --  
 19 I've looked at her records at Gundersen where she  
 20 was cared for, and there was absolutely nothing  
 21 going on that would limit her life to one year.  
 22 There's nothing in there at all that discussed  
 23 that.  
 24 But apparently from the report of  
 25 when she was highly intoxicated, she obviously had

10 (Pages 34 to 37)

Page 38

1 a very dark turn when I read the police report  
2 about her taking a gun and wanting to --  
3 putting -- whatever she was doing, she was in a  
4 very dark place.

5 But if you look at her medical  
6 records, there was nothing -- she didn't have  
7 advanced cancer. She didn't have any end-organ  
8 failure. She didn't have anything that would  
9 predictably weaken her life in the next year.  
10 That's out of thin air. There's no medical basis  
11 for that. But she was in a very dark place. It's  
12 more of a psychological assessment than it is  
13 medical.

14 BY MR. KNOTT:

15 Q Did you see that Ms. Boyer had any psychological  
16 diagnoses?

17 A Not that I'm aware of.

18 MS. MAKAR: Objection. Outside the  
19 scope.

20 BY MR. KNOTT:

21 Q Is it unusual in your practice that a patient  
22 would report that they have one year left to live  
23 without any basis in their medical condition?

24 MS. MAKAR: Objection. Form.

25 A I'm not -- I haven't -- I have not discussed this

Page 40

1 THE WITNESS: Fives minutes or less.

2 Okay, thanks.

3 (Brief recess taken from 11:00 a.m. to  
4 11:07 a.m.)

5 BY MR. KNOTT:

6 Q At any rate, Doctor, just if you need to cough, if  
7 you need to step out of the screen here, if you  
8 need anything, just let me know. I am going to  
9 start kind of turning through the pages of your  
10 report here, so I think we'll be moving along  
11 pretty quickly.

12 A Okay.

13 Q So Mrs. Boyer was provided clonidine.

14 Do you agree that the  
15 administration of clonidine was an appropriate  
16 intervention as far as it went?

17 A I'm not offering standard of care opinions. I'm  
18 only offering causation opinions. I have not  
19 weighed in on the appropriateness or the lack of  
20 appropriateness of giving her clonidine.

21 I'm only here to answer that she  
22 would have survived if she had been transferred to  
23 a hospital. I'm not giving opinions about the  
24 medication she received or the care she received.  
25 Other people are doing that.

Page 39

1 in my report. It has nothing to do with my  
2 opinions. She was drunk and dark. I know people  
3 who get very dark when they're drunk, and she was  
4 spewing things that were very dark, but they're  
5 not true. There was nothing about her life that  
6 limited her to a one-year life expectancy. It was  
7 out of thin air. It was a reflection of what  
8 alcohol did to her mind at that point in her  
9 darkness at that moment.

10 BY MR. KNOTT:

11 Q Is there a difference, Doctor, between difficulty  
12 breathing and shortness of breath?

13 A There could be. For most people they would relate  
14 to them as being the same thing. For some people  
15 difficulty breathing could be a mechanically  
16 difficult time breathing. So if somebody has rib  
17 pain and when they breathe in, they could say it's  
18 hard to breathe but they don't feel short of  
19 breath. But for the most part they're considered  
20 equivalent.

21 May I take a quick bathroom break?  
22 I'm sorry, this cold thing, I'm on these cold  
23 medicines and I need a quick break.

24 MR. KNOTT: Absolutely. It's not an  
25 endurance test.

Page 41

1 Q All right. Well, I don't think that's necessarily  
2 a basis for objection, but I respect your -- I  
3 respect your comment, Doctor, and I will -- I'll  
4 move on.

5 I -- well, at any rate, in your  
6 report, you cut and pasted a couple of sections  
7 from a document that was created by a correctional  
8 officer at the jail. That's Page 3 of your  
9 report. Are you there?

10 A Yes.

11 Q And, Doctor, can you just tell me, how would you  
12 characterize the vitals at 8:53, which is in that  
13 second segment?

14 A She had --

15 MS. MAKAR: Objection. Form.

16 A Well, her blood pressure was elevated.

17 BY MR. KNOTT:

18 Q Is there an objective scale of blood pressure to  
19 measure whether it's mildly elevated, moderately  
20 elevated, severely elevated?

21 A No, because it's contextual, meaning, to begin  
22 with, this is not a steady state blood pressure.  
23 It's one with a person coming in with, you know,  
24 being incarcerated, whatever her emotions are.  
25 But if you're having symptoms of blood pressure of

11 (Pages 38 to 41)

Page 42

1 142 over 92, it might have more significance than  
2 if you're not having symptoms and you have it  
3 measured casually in a doctor's office.

4 So it really isn't just a simple --  
5 you don't just compare it to an absolute curve.  
6 It depends on the context. If somebody's having  
7 chest pain or shortness of breath, a blood  
8 pressure of 142 over 92 could have more  
9 significance than if someone is comfortable.

10 Q How would you characterize 142 over 92 if it were  
11 in a patient that was comfortable in your office?

12 A Mild to moderately elevated.

13 Q You agree, Doctor, that that standing alone is not  
14 indicative of a hypertensive emergency?

15 A Alone, of course it isn't.

16 Q Do you know if you were provided EKG strips?

17 A I was -- sorry. Can you please repeat that?

18 Q Do you know if you were provided EKG strips?

19 A Yeah, I believe I was. Well, I was -- I was  
20 given -- I don't remember what EKG strips. I'm  
21 sorry, I don't recall what EKG strips you're  
22 referring to. When she got admitted to the  
23 hospital, I saw those EKG strips.

24 Q And at the top of Page 4 you reference EKG strips.

25 A At Gundersen.

Page 43

1 Q Correct.

2 A Yeah, I saw those. I said at Gundersen when she  
3 was admitted.

4 Q Right. And, Doctor, my question is --

5 A Okay.

6 Q -- is that your own interpretation of the strip,  
7 or are you taking that from a report?

8 A Well, it's my interpretation, but I don't know if  
9 that's different -- I don't recall what the report  
10 says anymore. It could be identical. I don't  
11 recall.

12 Q And is what you describe in the first paragraph of  
13 Page 4 an acute ischemic change?

14 A Yes. Those would be acute ischemic changes.

15 Q Can you explain that, Doctor, for a layperson?

16 A Well, the EKG, there's a segment of it called the  
17 ST segment. It's the end of the QRS complex to  
18 the beginning of the T-wave. And that QRS segment  
19 can be elevated, can be depressed or at baseline.

20 If you have more than a millimeter  
21 of depression of that ST segment, it frequently is  
22 an indicator of active ischemia to a section of  
23 heart muscle.

24 Here, there were inverted -- there  
25 was ST depression in what we call the inferior

Page 44

1 leads, all looking at the same part of the heart,  
2 leads II, III and F, aVF, as well as lateral  
3 leads, which would be V3 and V6, with the inverted  
4 T-waves.

5 So these EKGs not only are showing  
6 classic ischemic abnormalities, but they're also  
7 localized into an anatomic territory. So it's  
8 highly suggestive. But nothing is 100 percent  
9 proof. But this EKG is highly suggestive of an  
10 acute moment of ischemia to the left ventricle.

11 Q And is it your opinion to a reasonable degree of  
12 medical probability that she was experiencing  
13 ischemic injury throughout the afternoon?

14 A No, I didn't say that. I mean, she was showing  
15 acute ischemia. In part it could -- when you have  
16 a cardiomyopathy, as was her diagnosis for  
17 causation, you can have ischemia under certain  
18 stress states. And remember, that EKG was done  
19 after she had her cardiac arrest, so that could  
20 also be post arrest. But I mean -- but there was  
21 clearly, when she was admitted, EKG findings that  
22 are very consistent with an acute ischemia.

23 Q If you had an ischemic event sufficient to cause a  
24 change in the EKG, such as you've described, would  
25 you expect those to continue?

Page 45

1 A I don't know what you mean. Usually ischemia is  
2 transient. So you could have ST depression, which  
3 will then recover, because ischemia tends to come  
4 in waves. So, yeah, you would expect there to be  
5 recovery of those EKG changes.

6 Q And I guess the question I have, Doctor, is  
7 whether you're stating to a reasonable degree of  
8 medical probability that Ms. Boyer was  
9 experiencing ischemic -- experiencing ischemic  
10 chest pain throughout the afternoon of  
11 December 22nd?

12 MS. MAKAR: Objection. Form.

13 A I'm sorry. Can you please repeat that? I missed  
14 the first half.

15 BY MR. KNOTT:

16 Q The question that I have is whether you believe to  
17 a reasonable degree of medical probability that  
18 Ms. Boyer was experiencing ischemic chest pain the  
19 afternoon of December 22?

20 MS. MAKAR: Objection. Form.

21 A We can't know with absolute certainty. We do know  
22 that she did not have identifiable obstructive  
23 coronary disease, but that's not the only way you  
24 can get ischemic. Traditionally, you get ischemic  
25 or have heart attacks by a clot in an artery

12 (Pages 42 to 45)

<p style="text-align: right;">Page 46</p> <p>1 blocking the supply of blood. That wasn't her 2 problem. 3 But under certain stress states, 4 the increase of demand of oxygen can lead to that. 5 In her case, she did have chest pain radiating to 6 her left arm with shortness of breath, which are 7 common coronary types of symptoms, and she had 8 ischemic abnormalities, albeit after the code. So 9 she might have. We don't know. 10 BY MR. KNOTT: 11 Q Ischemic abnormalities after what, Doctor? 12 A After her cardiac arrest when she was admitted to 13 the hospital. 14 So she had, you know -- she had 15 chest pain and she had EKG abnormalities looking 16 like ischemia, but again, that was after the code, 17 so we don't know. 18 Q People with anxiety and elevated blood pressure 19 sometimes complain of chest pain and shortness of 20 breath; is that a fair statement? 21 MS. MAKAR: Objection. Form. 22 A People with anxiety and what? Chest pressure? 23 BY MR. KNOTT: 24 Q Elevated blood pressure. 25 A Yes, what about it?</p>	<p style="text-align: right;">Page 48</p> <p>1 So if somebody has acute onset of 2 chest pain, you don't know with the tools at hand 3 in your office whether it's coronary or not, so 4 you have to make decisions: It is a cardiac 5 arrest? It is prolonged? Is it episodic? Those 6 details can make a big difference. But again, 7 we're getting more into trying to diagnose her. 8 My causation opinion is simply if she were in the 9 hospital, she wouldn't have been dead. 10 BY MR. KNOTT: 11 Q Yeah, yeah. I'm trying to -- 12 A You want me to agree with you -- you're trying to 13 get me to say that she had things that were 14 stabilizing which leaned towards your standard of 15 care, and I'm not engaging in that. You're asking 16 me about whether her chest pain -- 17 Q Doctor -- Doctor, just let it go. Just stop. 18 A You're asking me things that are not in my report, 19 and you're asking me things that are not involved 20 in my opinion. 21 Q Yeah, I think you've been around the block, 22 Doctor, and you know how this works. And I'm 23 entitled to ask questions, and the fact that it's 24 not in your report does not mean you get to 25 determine relevance. So you're fine, we'll get</p>
<p style="text-align: right;">Page 47</p> <p>1 Q Sometimes complain of chest pain and shortness of 2 breath. 3 A Oh, my gosh. I mean, in theory, that could 4 happen, but I mean, that's just -- usually we 5 fight against that thinking because too many 6 people are dismissed from having coronary symptoms 7 by writing off symptoms of chest pain and 8 shortness of breath to anxiety. 9 But, in theory, yes, you can 10 have -- you can have chest pain and shortness of 11 breath without it being a cardiac issue. It's 12 possible. 13 Q Is it fair to say that many people present in 14 primary care settings with a complaint of chest 15 pain that has a noncardiac etiology? 16 MS. MAKAR: Objection. Form. 17 Foundation. Outside the scope. 18 A It's a bit of a vague question. I think that 19 chest pain is the most common symptom that brings 20 people to medical attention in both an office as 21 well as an add-on visit or an ER. But in those 22 cases, an evaluation must be performed to see if 23 it is coronary in most of those cases, and then 24 you find out whether it was coronary or not. Some 25 of them need to be in the hospital; some don't.</p>	<p style="text-align: right;">Page 49</p> <p>1 through this, and it will be fairly brief, but I'm 2 not going to have you lecture me or -- 3 A Sir, I don't mean to offend you. I'm not trying 4 to lecture you. It's just that my opinions are 5 very straightforward. And quite frankly, I think 6 that Dr. Wolff and I have no difference in our 7 opinions in terms of -- no one challenged my 8 causation opinion. No one. 9 Not one expert said -- my main 10 opinion is, had she been sent to the hospital 11 earlier, she would not have died. And no one has 12 disagreed with that in any report. So I'm really 13 confused why I'm even being deposed, because 14 everyone agrees with me. 15 Q So just let me kind of break it down into what 16 you've actually talked about in your report. 17 Again, I think there is a 18 difference, and I'm trying to -- I'm trying to 19 hone in on it. And I apologize, Doctor, I don't 20 have the understanding of these fine points in 21 medicine. 22 I guess I'm trying to understand 23 what you mean when you say that there was a 24 hypertensive event superimposed over a 25 cardiomyopathy.</p>



<p style="text-align: right;">Page 50</p> <p>1 MS. MAKAR: Objection. Form.</p> <p>2 BY MR. KNOTT:</p> <p>3 Q I hadn't asked a question yet. I'm trying to get</p> <p>4 there.</p> <p>5 And physiologically, Doctor, what</p> <p>6 are you proposing occurred when you say that the</p> <p>7 hypertensive event was superimposed on a</p> <p>8 cardiomyopathy?</p> <p>9 A Well, what I'm trying to get at in that comment,</p> <p>10 because her blood pressure had ups and downs, and</p> <p>11 we don't really have a track through the night,</p> <p>12 but the point is that because she has a</p> <p>13 cardiomyopathy, the same blood pressures that she</p> <p>14 might have formally tolerated become less</p> <p>15 tolerable because your heart's weakened. So if</p> <p>16 you have a normal ventricle and you have high</p> <p>17 blood pressure, it may not impact cardiac</p> <p>18 performance. But if you already have some damage</p> <p>19 to it and you haven't established cardiomyopathy,</p> <p>20 now the same blood pressures will lead to a higher</p> <p>21 risk of congestive symptoms.</p> <p>22 So what we do -- all we know -- the</p> <p>23 problem is we don't have enough information.</p> <p>24 She was having hypertensive</p> <p>25 episodes to the point of getting p.r.n. pills.</p>	<p style="text-align: right;">Page 52</p> <p>1 But in any given person, if you're</p> <p>2 having both chest pain, shortness of breath, high</p> <p>3 blood pressures that you're giving p.r.n.</p> <p>4 clonidine, we don't know what's going on, but it's</p> <p>5 concerning.</p> <p>6 Q Right. And I think you'll agree with me -- and</p> <p>7 I'll move to strike to the extent you're stating a</p> <p>8 standard of care opinion --</p> <p>9 A I wasn't really.</p> <p>10 Q -- but I am trying to -- I am trying to understand</p> <p>11 exactly what you believe was going on.</p> <p>12 And I understand the kind of</p> <p>13 general opinion that if she were in an ER, she</p> <p>14 would not have coded.</p> <p>15 My question to you is, and I think</p> <p>16 I understand this: Is it fair to say that you do</p> <p>17 not have enough data to give an opinion that she</p> <p>18 was suffering chest pain due to cardiac ischemia</p> <p>19 between 7:00 and 8:00 p.m. on December 22?</p> <p>20 MS. MAKAR: Objection.</p> <p>21 Mischaracterization of testimony. Form.</p> <p>22 Foundation.</p> <p>23 A Well, we know that she reported having episodic</p> <p>24 pain all day long, but if you're saying that same</p> <p>25 pain reported between 7:00 and 8:00, whatever, we</p>
<p style="text-align: right;">Page 51</p> <p>1 She was not able to take her chronic medications.</p> <p>2 She, you know, wasn't getting her narcotics, so</p> <p>3 there could theoretically be some withdrawal from</p> <p>4 it. But at that point all we know is she's having</p> <p>5 chest discomfort to the left arm and she's having</p> <p>6 hypertensive episodes and shortness of breath.</p> <p>7 And then all we know there is that we don't have</p> <p>8 any data about what happened to her, and the next</p> <p>9 thing we know she's coding.</p> <p>10 And to that degree, all I can say</p> <p>11 is that had she been in the hospital, she never</p> <p>12 would have coded, or if she did code, she would</p> <p>13 have been saved immediately. Because whatever led</p> <p>14 to her code didn't kill her. It caused her to</p> <p>15 code in the -- in the jail, and the delay</p> <p>16 intrinsic of an out-of-hospital cardiac arrest is</p> <p>17 what caused her brain to die. But she didn't die</p> <p>18 of any medical reason. It just caused her to</p> <p>19 code.</p> <p>20 And all I'm saying is had she been</p> <p>21 in the hospital, she never would have coded. They</p> <p>22 would have prevented it or they would have</p> <p>23 resuscitated immediately. But I don't know what</p> <p>24 caused her to code. We don't have enough data.</p> <p>25 We just know a lot of things were going on.</p>	<p style="text-align: right;">Page 53</p> <p>1 don't know if it's ischemic.</p> <p>2 BY MR. KNOTT:</p> <p>3 Q And --</p> <p>4 A In retrospect, we don't really know if it's</p> <p>5 ischemic. It's just hard to know.</p> <p>6 Q And you don't hold an opinion that she was</p> <p>7 experiencing an arrhythmia during the day on the</p> <p>8 22nd. Fair?</p> <p>9 MS. MAKAR: Objection.</p> <p>10 A We know she had a long enough arrhythmia to cause</p> <p>11 her to have a hypoxic seizure, which was captured</p> <p>12 on video, but we don't know whether or not she was</p> <p>13 having shorter runs of arrhythmias like V-tach</p> <p>14 earlier in the day. Between her potassium being</p> <p>15 reduced and her different symptoms, it's possible</p> <p>16 she was having non-sustained arrhythmias. What we</p> <p>17 do know what happened is she arrested. And that's</p> <p>18 documented.</p> <p>19 BY MR. KNOTT:</p> <p>20 Q And you understand, Doctor, as a scientist and as</p> <p>21 a experienced expert witness that being able to</p> <p>22 say that something is more probable than not is an</p> <p>23 important distinction.</p> <p>24 You understand that, correct?</p> <p>25 MS. MAKAR: Objection. Form.</p>



Page 54

1 **A Of course I understand that.**  
 2 BY MR. KNOTT:  
 3 Q Yeah. And you can't say that it is more probable  
 4 than not that she was experiencing arrhythmia  
 5 during the day on the 22nd?  
 6 MS. MAKAR: Objection.  
 7 **A Correct. Correct, I cannot say that.**  
 8 BY MR. KNOTT:  
 9 Q I have something cued up here, Doc, and I just  
 10 want your input on it.  
 11 We can mark this as Exhibit 121.  
 12 It's GHS1339. Doctor, can you read that? I can  
 13 blow it up a little.  
 14 **A Do you want me to read it out loud --**  
 15 Q Read it to yourself.  
 16 **A -- or are you asking me if I can read it?**  
 17 Q It's the note of the emergency room provider the  
 18 morning of December 23.  
 19 **A (Witness reads.) Yeah, I see that.**  
 20 Q And I've highlighted the sentence that begins --  
 21 or the passage that begins, "Initial EKG," and it  
 22 ends with "begin with."  
 23 Can you interpret that for us,  
 24 Doctor, if you're able, as to what the emergency  
 25 room physician and cardiologist believe occurred

Page 55

1 in terms of the EKG?  
 2 **A Yes. They're saying that the paramedic, which**  
 3 **often do 12-lead EKGs, found there to be ST**  
 4 **depression in the leads I discussed earlier, II,**  
 5 **III and aVF. Those are inferior leads. And there**  
 6 **was ST elevation in lead aVL, but that's not that**  
 7 **important. But there was ST depression in the**  
 8 **inferior leads, but then that resolved. Again,**  
 9 **ischemia does tend to resolve. And they're not**  
 10 **100 percent sure if that ischemia was present to**  
 11 **provoke the arrest or if it was a consequence of**  
 12 **the arrest. And I agree with that, too.**  
 13 **But there was no reason to take her**  
 14 **to the cath lab because it had resolved.**  
 15 Q Okay. I've put on the screen GHS1559, which we'll  
 16 mark as Exhibit 122.  
 17 Have you seen that before, Doctor?  
 18 It's an EKG strip.  
 19 **A Yes, I have.**  
 20 Q And one of the providers wrote at the bottom,  
 21 "torsades de pointes." I think that's how you  
 22 pronounce it.  
 23 **A Yes. P-O-I-N-T-E-S. So it would be "pointes,"**  
 24 **but you're pronouncing it with a French accent.**  
 25 Q Okay. Thank you. I'd rather pronounce it with my

Page 56

1 Iowan accent.  
 2 Doctor, do you agree that that  
 3 shows that the strip is accurately interpreted as  
 4 torsades pointes?  
 5 **A Just say torsades. T-O-R-S-A-D-E-S. Torsades.**  
 6 **Yes, it is torsades.**  
 7 Q And torsades is a non-ischemic pattern; is that  
 8 fair?  
 9 **A It's not ischemia. It's a form of ventricular**  
 10 **tachycardia. It can occur in ischemia. It has no**  
 11 **comment on whether there's ischemia. It's just a**  
 12 **form of V-tach. It can be precipitated by**  
 13 **electrolyte, but it doesn't mean there isn't an**  
 14 **element of ischemia. It's just neutral on that.**  
 15 Q So isn't it true, Doctor, that torsades is  
 16 pathognomonic of an electrolyte imbalance?  
 17 MS. MAKAR: Objection. Form.  
 18 **A It is not. It is most common in patients with**  
 19 **prolonged QT intervals. That can occur from**  
 20 **ischemia and heart attacks, that can occur from**  
 21 **medications with normal electrolytes, and it can**  
 22 **occur in abnormal electrolytes.**  
 23 **So, for example, I've seen patients**  
 24 **have torsades who received the drug Lidocaine, and**  
 25 **they get too much of it, their QT interval**

Page 57

1 **prolonged and they have torsades with normal**  
 2 **potassium. Certainly this patient has low**  
 3 **potassium, which means their threshold to going**  
 4 **into torsades is lower.**  
 5 **So if a person who has a potassium**  
 6 **of two-three gets ischemic, it's more likely their**  
 7 **V-tach will be torsades. It's just a form of**  
 8 **V-tach that's influenced by things that prolong**  
 9 **the QT interval. And it's not -- it's not**  
 10 **diagnostic of an electrolyte problem.**  
 11 BY MR. KNOTT:  
 12 Q It's associated with an electrolyte problem?  
 13 **A Can be associated with certain electrolyte**  
 14 **problems, but that's not the only reason why it**  
 15 **occurs.**  
 16 Q And if I understood --  
 17 **A It's more common with medications than it is with**  
 18 **electrolytes.**  
 19 Q Okay. If I understood your response correctly,  
 20 this pattern, torsades, presents in response to  
 21 ischemia, one; medication, two; torsades, three?  
 22 I mean electrolyte imbalance, three?  
 23 **A What did you say one was?**  
 24 Q Ischemia.  
 25 **A No, I didn't say ischemia. What I'm saying is**

15 (Pages 54 to 57)

Page 58

1 that this form of ventricular tachycardia, it's a  
2 form of V-tach, it is more likely to occur if  
3 someone's going to have ventricular tachycardia in  
4 conditions that prolong the QT interval. Those  
5 conditions can include low potassium,  
6 electrolytes. Those conditions can include a lot  
7 of different medications, which is actually the  
8 most common form of torsades is medications that  
9 prolong the QT interval.

10 Ischemia, especially in the setting  
11 of cardiomyopathy, or dead or damaged muscle, also  
12 is at risk for a long QT interval.

13 But the point is that if somebody  
14 has an electrolyte abnormality and then they get  
15 ischemic, if the ischemia is going to cause  
16 V-tach, if they have a low potassium, it's going  
17 to be torsades V-tach.

18 So you have no diagnostic utility  
19 here. It just says that this patient had V-tach  
20 and it was torsades. Unquestionably, the fact  
21 that the potassium was low is a strong indicator  
22 of that being the reason why the V-tach is  
23 torsades, but it doesn't tell you that that's what  
24 initiated the torsades.

25 Q She had a second episode of V-tach the morning of

Page 60

1 seen people who have Lidocaine toxicity go into  
2 V-tach torsades and it doesn't stop. It will go  
3 on for hours while being shocked, so you have to  
4 put in a pacemaker and speed up the heart. The  
5 point is she wasn't having it every five seconds.  
6 She had periods of no torsades, which makes an  
7 argument that it wasn't only electrolytes.

8 Q When did she have periods of no torsades?

9 A When she was admitted. She wasn't having every  
10 five minutes getting shocked out of torsades.

11 Q Do you agree that a potassium level of 2.3 puts a  
12 person at substantial risk of arrhythmia?

13 MS. MAKAR: Objection. Form.

14 A Yes. But the only qualification I'd have on that  
15 is that in her cardiac arrest, she got multiple  
16 doses of epinephrine. That's standard for all  
17 ACLS protocols. And epinephrine injections will  
18 drop your serum potassium.

19 So when her potassium went to 2.3,  
20 although it came back to 2.6, it's not 100 percent  
21 clear if it really was 2.3 before her arrest,  
22 because she got a lot of epinephrine. But she did  
23 have 2.6 before she was hospitalized and didn't  
24 have an arrhythmia.

25

Page 59

1 December 24th?

2 A Yes.

3 Q Do you agree that that was likely precipitated by  
4 the electrolyte imbalance?

5 A Well, there were orders trying to correct it, so I  
6 don't know if that's -- remember, when this  
7 patient had a code, there's -- you know, even  
8 though she recovered from the acute code, the  
9 heart gets even further damaged because there was  
10 a code and more irritable. So you might have more  
11 V-tach just because you already survived a code.

12 Q And anything, in terms of a potassium level,  
13 anything below 3.0 is profoundly reduced.

14 Do you agree with that?

15 MS. MAKAR: Objection. Form.

16 A A, I wouldn't have a cutoff for profound. People  
17 with cardiomyopathies of any type, we try to keep  
18 the potassium over 4. And we find under 3.5 to be  
19 more unacceptable, and then as you drop, it  
20 progressively has greater and greater instability.  
21 But we don't have a single cutoff that says above  
22 3, lower than 3. But the lower you get, the worse  
23 it is in terms of risk.

24 But, on the other hand, she was not  
25 in refractory torsades all day. It wasn't -- I've

Page 61

1 BY MR. KNOTT:

2 Q She had 2.6?

3 A As an outpatient, yes.

4 Q No one can know what her potassium level was on  
5 the day of her admission to the jail. You'd agree  
6 with that?

7 A Correct.

8 THE STENOGRAPHER: I'm sorry? Did you  
9 say "correct"?

10 A Yes. Just stretching.

11 BY MR. KNOTT:

12 Q Does pulmonary edema cause chest pain?

13 A It could, but usually chest pain is part of the  
14 reason why someone has pulmonary edema. But  
15 developing pulmonary edema could independently  
16 cause chest pain, yes, it's possible.

17 Q Pulmonary edema could cause shortness of breath.  
18 True?

19 A Yeah, definitely causes shortness of breath, and  
20 in theory can cause chest pain.

21 MR. KNOTT: Am I still sharing?

22 MS. MAKAR: No.

23 BY MR. KNOTT:

24 Q I want to look at your report, Doctor, Page 5.

25 A Okay.

16 (Pages 58 to 61)

Page 62

1 Q In the third paragraph, second sentence, "Her  
2 cardiac arrest was provoked by her hypertensive  
3 episode" --  
4 **A I'm sorry. The third full paragraph? I'm not  
5 sure -- Page 5?**  
6 Q Page 5, third full paragraph.  
7 **A That begins with "It is my opinion"?**  
8 Q Correct.  
9 **A Okay.**  
10 Q But I'm focused on the second sentence.  
11 **A Yes.**  
12 Q "Her cardiac arrest was provoked by her  
13 hypertensive episodes recorded during the  
14 afternoon and evening of 12/22/19" --  
15 **A Yes.**  
16 Q -- open paren, "(provoking congestive heart  
17 failure and coronary artery ischemia)," closed  
18 paren, period.  
19 Do you have -- strike that.  
20 What is the basis for your  
21 statement there that she had coronary artery  
22 ischemia?  
23 **A Well, the EKG showed -- a lot of people have  
24 cardiac arrest but they don't show focal ischemia  
25 on a 12-lead. She had ischemia on the EKG. She**

Page 63

1 **had a ventricular tachycardia arrest. She had  
2 chest pain, shortness of breath, and high blood  
3 pressure.**  
4 **So all together, that would be my  
5 most likely formulation of what occurred. Oddly  
6 enough, that has nothing to do with my causation  
7 opinion, in that no matter what she had, she would  
8 have survived if she were in the emergency room  
9 before it happened.**  
10 **But my best formulation, the one  
11 that makes the most sense, so my opinion is with a  
12 reasonable degree of medical certainty, not  
13 absolute certainty, reasonable degree of medical  
14 certainty something happened where her blood  
15 pressure was going up. We don't have any data as  
16 to how high it went after the last check. And,  
17 that led -- and more likely than not, her blood  
18 pressure going up would make chest pain and  
19 shortness of breath happen in her case.**  
20 **So I think the best formulation of  
21 what happened is, since she had heart disease, was  
22 that she had hypertension which led to congestion,  
23 and in her case, because of the underlying  
24 structural heart disease, transient ischemia that  
25 led to V-tach and her arrest. I think it's the**

Page 64

1 **most logical assessment based on the normal  
2 methodology we use to evaluate a patient in the  
3 real world.**  
4 Q And I'm just trying to focus in on some individual  
5 pillars of your opinion here, Doctor. I  
6 appreciate that. I think I understand your  
7 overall opinion.  
8 **A It's not really a pillar of my opinion, of course,  
9 because it doesn't matter what she coded from. If  
10 she were in a hospital, she would either have not  
11 arrested or she would have been survived with a  
12 normal brain, because she only died because her  
13 brain was abnormal.**  
14 Q I've been given a report, Doctor, and I'm trying  
15 to understand it. Okay?  
16 **A Yes.**  
17 Q There were no findings of pathology in her  
18 coronary arteries on autopsy?  
19 **A Yes. We know she did not have coronary disease.  
20 Right.**  
21 Q And so what I'm trying to understand, Doctor, is  
22 that reference in that particular paragraph to  
23 coronary artery ischemia. What are you  
24 postulating occurred in her coronary arteries  
25 that -- that contributed to her death?

Page 65

1 **A I'm sorry. It's probably just the use of coronary  
2 artery ischemia. It's just the term we use for  
3 ischemia. Ischemia is any time the demand for  
4 fuel in the heart is greater than the blood supply  
5 delivered.**  
6 **Now, traditionally when we think of  
7 coronary ischemia, we think of an obstructed  
8 coronary artery with atherosclerosis plus or minus  
9 a clot that could be dynamic.**  
10 **But the other ways you could have  
11 coronary ischemia is an increase in demand due to  
12 a profound stress on the heart. And high blood  
13 pressure cannot only increase demand, it can also  
14 reduce supply by making the muscle tighten up, so  
15 it would be at a microvascular bed level. So you  
16 can have ischemia without having obstructive  
17 coronary disease. So that's all I'm saying.**  
18 Q Just want to make sure that I understand, Doctor.  
19 She first reported symptoms at  
20 3:00 p.m. on Sunday, December 22. That's  
21 referenced in your report?  
22 **A She was first reported that she had been having  
23 symptoms that day. That's not when she first had  
24 symptoms. She reported that she was having  
25 episodic symptoms all day. Right? I just want to**

17 (Pages 62 to 65)

Page 66

1 **be clear about that.**  
 2 Q Well, that's a fact question that will have to be  
 3 resolved. But let's assume -- let's just pinpoint  
 4 3:00 p.m. when she first reported symptoms.  
 5 You do not have a basis to say that  
 6 she was experiencing ventricular tachycardia at  
 7 that time, correct?  
 8 A **Correct. Of course.**  
 9 Q Of course not?  
 10 A **Of course I never said she had ventricular**  
 11 **tachycardia at that time. There's no basis to**  
 12 **know if she did or didn't.**  
 13 Q You agree that she more likely than not did not  
 14 have an arrhythmia at that time?  
 15 MS. MAKAR: Objection. Form.  
 16 A **I don't know whether -- you can't determine**  
 17 **whether she was having non-sustained bursts of**  
 18 **V-tach. There's no way to know.**  
 19 BY MR. KNOTT:  
 20 Q You state in your report that her hypokalemia was  
 21 a substantial contributing factor, correct?  
 22 A **Towards her having V-tach, yes.**  
 23 Q You're, of course, not able to state the relative  
 24 contribution of her hypokalemia versus her  
 25 congestive heart failure?

Page 67

1 A **There's no way to know the role of either one. I**  
 2 **think her low potassium was a significant**  
 3 **contributing factor.**  
 4 Q Is a potassium level of 2.3 sufficiently depressed  
 5 to have triggered a ventricular arrhythmia and  
 6 arrest on its own?  
 7 A **In theory, yes. But I figure it's very unlikely**  
 8 **because her arrest just didn't happen out of the**  
 9 **blue. It happened in the setting of her needing**  
 10 **urgent drugs for blood pressure control and her**  
 11 **having chest pain that day. I don't think you**  
 12 **could exclude those.**  
 13 **So I can't give you that with**  
 14 **absolute certainty, but I think with reasonable**  
 15 **certainty the low potassium lowered the trigger of**  
 16 **firing, but something else pulled the trigger. It**  
 17 **was just a hairpin trigger.**  
 18 Q If I ask you to define major hypertension as you  
 19 use it on Page 5, I assume you'd tell me that it's  
 20 relative to the patient?  
 21 MS. MAKAR: Objection.  
 22 A **Yes, relative to the patient.**  
 23 BY MR. KNOTT:  
 24 Q We looked previously at the particular cut and  
 25 paste on Page 3. Do you agree with me that the

Page 68

1 vitals that are shown on Page 3 are inconsistent  
 2 with a sustained ventricular arrhythmia?  
 3 MS. MAKAR: Objection.  
 4 A **There's no chance -- she could not have had a**  
 5 **sustained arrhythmia. She would have coded.**  
 6 **So -- she could have AFib or other arrhythmias,**  
 7 **but in terms of ventricular arrhythmias, she could**  
 8 **not have had a sustained ventricular arrhythmia at**  
 9 **that point.**  
 10 BY MR. KNOTT:  
 11 Q You quote in your report Gundersen records that  
 12 had -- that identify the contribution of  
 13 electrolyte imbalance as a source of the arrest.  
 14 Her providers were identifying that as a likely  
 15 cause of her arrest, correct?  
 16 A **Yes.**  
 17 Q Are you aware of any report from Gundersen that  
 18 identifies episodic hypertension as a contributor  
 19 to her arrest?  
 20 A **I didn't see anything. But on the other hand, I**  
 21 **don't know whether they were aware of what was**  
 22 **going on in the present -- in the jail. I don't**  
 23 **know if they were aware she had episodic chest**  
 24 **pain on again/off again that day. Because she**  
 25 **came in with cardiac arrest, she couldn't give a**

Page 69

1 **history. So I don't know whether they were aware**  
 2 **she had the need for p.r.n. clonidine, so I don't**  
 3 **know what they knew. But nor is it that**  
 4 **important. It has nothing to do with my opinion,**  
 5 **but I don't know if they knew.**  
 6 Q Doctor, how is malignant hypertension defined?  
 7 A **It's defined by a person having end-organ damage**  
 8 **as a result of hypertension, usually with**  
 9 **diastolics that go over 100 or 110. But again, it**  
 10 **depends on the context of the person. But it**  
 11 **usually means high blood pressure that is**  
 12 **clinically believed to be causing heart failure or**  
 13 **chest pain. Symptomatic hypertension on a**  
 14 **cardiovascular system. Did I use the word**  
 15 **"malignant hypertension" in my report? Because I**  
 16 **don't recall that. I don't think I used the word**  
 17 **malignant hypertension, because she didn't have**  
 18 **malignant hypertension. I never raised that as an**  
 19 **issue.**  
 20 Q Okay. What I was getting at is, do you have any  
 21 understanding of what the source was of her  
 22 potassium wasting disorder?  
 23 A **No. She was identified to have it as an**  
 24 **outpatient, and I don't know what caused her**  
 25 **disorder. She was not really on a diuretic to**

18 (Pages 66 to 69)

Page 70

1 explain it, but I don't know what was causing it.  
 2 Q You agree that it's most likely some sort of  
 3 kidney disorder resulting from her childhood  
 4 cancer treatment?  
 5 A Maybe. I'm not too sure that would cause -- I  
 6 don't know how long she had her potassium problem.  
 7 Q Is it potentially related to her -- her chronic  
 8 hypertension?  
 9 MS. MAKAR: Objection. Form.  
 10 Foundation.  
 11 A I'm not sure I understand what you're saying. You  
 12 don't get potassium wasting from being  
 13 hypertensive, but you do get it from medications.  
 14 But she's been on the drug Vasotec for a long  
 15 time, and that raises potassium. But despite  
 16 that, she still had low potassium. And I don't  
 17 recall her being on a potassium-wasting drug, so I  
 18 don't know what the basis is. I'm not sure.  
 19 BY MR. KNOTT:  
 20 Q What was the drug you said, Vasotec?  
 21 A Sorry. Lisinopril. Lisinopril. It's a cousin.  
 22 She was on lisinopril 40 milligrams forever.  
 23 Since at least 2011 I saw her on it, the same  
 24 dose, all those years.  
 25 Q And with respect to your opinion on life

Page 71

1 expectancy, you referenced the CDC tables,  
 2 correct?  
 3 A Yes.  
 4 Q And where did you locate those, Doctor?  
 5 A Online. You can look up CDC life tables for the  
 6 year 2019, whatever the year.  
 7 Q Did you do that in this case?  
 8 A Yes.  
 9 Q And obviously, they don't have a cohort for  
 10 individuals with congestive heart failure, right?  
 11 MS. MAKAR: Objection. Form.  
 12 A They do in that what you get is the average life  
 13 expectancy for a population. For any given  
 14 population of people, let's take all 41-year-olds,  
 15 if they get 40 more years, that's 81. You could  
 16 break all 40-year-olds into three theoretic  
 17 groups. One group are the healthiest 41-year-olds  
 18 with zero medical problems in good shop. You know  
 19 they're going to live longer than the average of  
 20 81; these are the people that make it into their  
 21 late 80s or 90s or older.  
 22 Then you have a population of  
 23 people who are 41 who have horrible short-term  
 24 prognoses; they're on dialysis with no hope of  
 25 getting a transplant, or they have major organ

Page 72

1 failure or malignant cancer, and they're not going  
 2 to make it five years. And then you have the  
 3 average 41-year-old who have medical problems.  
 4 That's baked into the average. It's not --  
 5 there's no such thing as a normal life expectancy.  
 6 There is an average life expectancy. Reduced her  
 7 from the average. But the average includes people  
 8 who have different problems.  
 9 And her heart failure, by the way,  
 10 was not much of an issue as an outpatient. She had  
 11 a cardiomyopathy, but she was reported on her last  
 12 visit prior to this admission of having no  
 13 shortness of breath. So she had Class I heart  
 14 failure, which means she had no known limit. So  
 15 she had disease but no major -- she wasn't in  
 16 sustained or chronic heart failure as a symptom.  
 17 BY MR. KNOTT:  
 18 Q So even just -- Doctor, do you consult the CDC  
 19 tables in your day-to-day practice?  
 20 A On rare occasions I do, but usually not. I think  
 21 through my practice of being in medicine for over  
 22 40 years, 45 years, actually, now, I think I begin  
 23 to, you know, understand the impact of disease  
 24 states on life expectancy. The tables just give a  
 25 more formal understanding of that, a quantitative

Page 73

1 understanding.  
 2 Q In this case, though, you started with the CDC  
 3 tables, right?  
 4 A Right.  
 5 Q And in your daily practice, if someone wanted to  
 6 know their prognosis and their outlook going  
 7 forward, you would use your knowledge of that  
 8 particular patient and you would not consult the  
 9 CDC table. Fair?  
 10 A Yes and no, 'cause the table corresponds to what I  
 11 already know in medicine. And I usually don't  
 12 give people a life expectancy. I would just tell  
 13 them that they have a disease which has risk, and  
 14 I deal it from a prospective viewpoint with  
 15 telling them the steps they could do to optimize  
 16 it. But I usually don't say to a patient, you  
 17 have a 31.3 -- 31.3 year life expectancy. The  
 18 population --  
 19 Q Can you answer my question? In speaking to your  
 20 patients, you're not likely to consult the CDC  
 21 table to talk about their prognosis?  
 22 A Well, it's not a table for prognosis. It's an  
 23 average life expectancy for population, so it  
 24 wouldn't be part of day-to-day practice.  
 25 Q I didn't hear the end of that, Doctor.

19 (Pages 70 to 73)



<p style="text-align: right;">Page 74</p> <p>1 <b>A It would not be part of day-to-day practice to</b>  2 <b>quote a population survival curve.</b>  3 Q And in this case, even though you described how  4 the medical conditions are baked into the CDC  5 curve, you did factor in your assessment  6 congestive heart failure?  7 <b>A Yeah, but her heart failure was not a major factor</b>  8 <b>in her survival, in part, because she didn't have</b>  9 <b>clinical heart failure. She had damage to the</b>  10 <b>left ventricle, which is different. But she was</b>  11 <b>not being treated with diuretics. She wasn't</b>  12 <b>admitted to the hospital with recurrent shortness</b>  13 <b>of breath. So she didn't really have congestive</b>  14 <b>heart failure. She was found to have a</b>  15 <b>cardiomyopathy at a very low burning level that</b>  16 <b>was not interfering with her day-to-day function.</b>  17 <b>She never had --</b>  18 Q Page 8 of your report, Doctor. I don't -- I don't  19 want to argue about this. I'm trying to get at  20 your methodology. Her only serious long-term  21 medical problem was her underlying cardiomyopathy?  22 <b>A But that's not heart failure. That's</b>  23 <b>cardiomyopathy.</b>  24 Q Okay.  25 <b>A There's a difference between cardiomyopathy and --</b></p>	<p style="text-align: right;">Page 76</p> <p>1 your assessment of her life expectancy. Fair?  2 MS. MAKAR: Objection. Form.  3 Foundation.  4 <b>A It's baked in there a little bit, yes, but it's</b>  5 <b>not a major factor in her life expectancy. If she</b>  6 <b>had coronary disease or cancer it would be, but</b>  7 <b>she didn't have cancer on her autopsy, and she</b>  8 <b>didn't have coronary disease. But of course, you</b>  9 <b>would have to weigh it. And remember, cigarette</b>  10 <b>smokers 22 percent -- probably 20 percent of all</b>  11 <b>40-year-olds are smokers, so that's somewhat baked</b>  12 <b>into the average. That's already part of the</b>  13 <b>average.</b>  14 BY MR. KNOTT:  15 Q So I want you to -- I want to tick through her  16 medical conditions and tell me whether you  17 considered them as a serious long-term medical  18 problem that impacted her life expectancy versus  19 something that was baked into the tables.  20 Hypertension; was that individually  21 considered for Ms. Boyer?  22 <b>A That's baked into the table.</b>  23 Q So you did not consider it independently?  24 MS. MAKAR: Objection.  25 <b>A It's part of weighing everything all together.</b></p>
<p style="text-align: right;">Page 75</p> <p>1 <b>you can have a cardiomyopathy and be totally</b>  2 <b>asymptomatic.</b>  3 Q Okay. All right. So your methodology, sir, was  4 to start with the CDC life table. And the single  5 medical condition that you considered was her  6 underlying cardiomyopathy. Fair?  7 MS. MAKAR: Objection. Form.  8 <b>A Those are things that potentially can jeopardize</b>  9 <b>life expectancy, yes. Her other problems were</b>  10 <b>meaningful but they weren't threatening her --</b>  11 <b>(unintelligible) --</b>  12 THE STENOGRAPHER: I'm sorry, Doctor. I  13 didn't hear you. "Her other problems were  14 meaningful but they" --  15 <b>A Her other problems were meaningful to her, but</b>  16 <b>they were not jeopardizing her life expectancy.</b>  17 BY MR. KNOTT:  18 Q Mrs. Boyer was -- or Ms. Boyer was a smoker.  19 Does that have an impact on life  20 expectancy?  21 <b>A It certainly can. Certainly would potentially add</b>  22 <b>to weighing down. But of note, despite her</b>  23 <b>coronary risk factors, she had clean coronary</b>  24 <b>arteries at 41, which is good news.</b>  25 Q Her smoking is not a factor that you considered in</p>	<p style="text-align: right;">Page 77</p> <p>1 BY MR. KNOTT:  2 Q Yeah, I understand that.  3 She was narcotic dependent. Is  4 that a factor that you considered as impacting her  5 life expectancy?  6 <b>A No. She --</b>  7 MS. MAKAR: Objection.  8 <b>A She wasn't taking an illegal drug or street drugs.</b>  9 <b>She was getting it prescribed. They were trying</b>  10 <b>to deal with her chronic pain syndrome, so that</b>  11 <b>should not impact her life expectancy. It's just</b>  12 <b>terrible that she had so much pain, but it's not a</b>  13 <b>life expectancy issue.</b>  14 BY MR. KNOTT:  15 Q Did you consider or dig into the source of her  16 abdominal pain when you're considering her life  17 expectancy?  18 <b>A It was obviously pain that was residual from the</b>  19 <b>cancer she had and the multiple complications of</b>  20 <b>bowel obstructions and issues she had in her</b>  21 <b>pelvis and abdomen. But there's no delving into</b>  22 <b>it. I mean I wasn't able to examine her. But to</b>  23 <b>that degree she had -- it was a quality of life</b>  24 <b>issue.</b>  25 Q She had asthma. That's not a factor that you</p>



<p style="text-align: right;">Page 78</p> <p>1 considered independently?</p> <p>2 MS. MAKAR: Objection. Form.</p> <p>3 Foundation.</p> <p>4 <b>A It's one of those things that's baked into the</b></p> <p>5 <b>average of the life expectancy curve.</b></p> <p>6 BY MR. KNOTT:</p> <p>7 Q Doctor, there's -- there's --</p> <p>8 <b>A Her asthma was not horrible. It wasn't as if she</b></p> <p>9 <b>went to ERs and was getting intubated or being in</b></p> <p>10 <b>ICUs or even having recurrent ER visits. She had</b></p> <p>11 <b>mild asthma. That's not going to affect -- that's</b></p> <p>12 <b>baked into the average life expectancy curve.</b></p> <p>13 <b>There's a magnitude to these things. And I think</b></p> <p>14 <b>she's only been a smoker --</b></p> <p>15 Q Doctor, there's -- there's data available on the</p> <p>16 impact of smoking on life expectancy, isn't there?</p> <p>17 <b>A I think it depends on how much you smoke, because</b></p> <p>18 <b>I think she was a half a pack a day.</b></p> <p>19 Q And there's data available. You didn't consult</p> <p>20 it. Fair?</p> <p>21 MS. MAKAR: Objection. Form.</p> <p>22 Foundation.</p> <p>23 <b>A It's baked into her life expectancy.</b></p> <p>24 BY MR. KNOTT:</p> <p>25 Q So you didn't consult any other -- any independent</p>	<p style="text-align: right;">Page 80</p> <p>1 which you did not consider individually in</p> <p>2 assessing her life expectancy?</p> <p>3 MS. MAKAR: Objection. Form.</p> <p>4 Foundation. Misstates the record.</p> <p>5 <b>A I'm sorry. I missed something you said. What did</b></p> <p>6 <b>you say?</b></p> <p>7 BY MR. KNOTT:</p> <p>8 Q She had a potassium-wasting condition which you</p> <p>9 did not consider individually?</p> <p>10 <b>A It would have been manageable. I don't know what</b></p> <p>11 <b>caused it, but they -- an endocrine workup would</b></p> <p>12 <b>be necessary, and whatever cause, it would be</b></p> <p>13 <b>treatable.</b></p> <p>14 <b>There was no cancer found on</b></p> <p>15 <b>autopsy, so she wasn't dealing with a tumor.</b></p> <p>16 Q And Ms. Boyer had a history of noncompliance with</p> <p>17 her potassium supplement. You're aware of that?</p> <p>18 MS. MAKAR: Same objection.</p> <p>19 <b>A A lot of people don't like taking potassium</b></p> <p>20 <b>supplements. But her problem is way beyond</b></p> <p>21 <b>potassium supplements. It's a different issue.</b></p> <p>22 <b>It's physiologic.</b></p> <p>23 BY MR. KNOTT:</p> <p>24 Q Do you think that walking around on the streets</p> <p>25 with a potassium level below 3 creates a</p>
<p style="text-align: right;">Page 79</p> <p>1 data on her -- the impact of tobacco abuse on life</p> <p>2 expectancy?</p> <p>3 <b>A I didn't --</b></p> <p>4 MS. MAKAR: Form.</p> <p>5 <b>A -- do research, because I know clinically the</b></p> <p>6 <b>impact of different abnormalities, including</b></p> <p>7 <b>cigarette smoking and how it has its impact on</b></p> <p>8 <b>both quality of life and survival. So I'm aware</b></p> <p>9 <b>of these things. I didn't have to do research.</b></p> <p>10 BY MR. KNOTT:</p> <p>11 Q She had refractory, urinary and fecal</p> <p>12 incontinence. Is that a factor that you</p> <p>13 considered independently in her life expectancy?</p> <p>14 MS. MAKAR: Objection. Form.</p> <p>15 Foundation. Misstates the record.</p> <p>16 <b>A It was considered as a quality of life issue, but</b></p> <p>17 <b>not one that impacted her life expectancy.</b></p> <p>18 BY MR. KNOTT:</p> <p>19 Q So the answer is no?</p> <p>20 MS. MAKAR: Objection. Form.</p> <p>21 <b>A I did -- there's no impact it would have that</b></p> <p>22 <b>would significantly impact life expectancy. It's</b></p> <p>23 <b>a chronic manageable problem.</b></p> <p>24 BY MR. KNOTT:</p> <p>25 Q She had some sort of potassium-wasting condition</p>	<p style="text-align: right;">Page 81</p> <p>1 substantial risk of sudden death?</p> <p>2 MS. MAKAR: Same objections.</p> <p>3 <b>A I think it was an easily manageable problem, and I</b></p> <p>4 <b>think that this certainly -- had she had the</b></p> <p>5 <b>torsades and survived it in the ER, it would have</b></p> <p>6 <b>become the focus of a workup to find out what's</b></p> <p>7 <b>going on, as well as within reasonable certainty</b></p> <p>8 <b>implanting a defibrillator, because that is a risk</b></p> <p>9 <b>to her. And this arrest, if it occurred, would</b></p> <p>10 <b>have required her to get a defibrillator. That or</b></p> <p>11 <b>absolutely diagnose what's going on and then find</b></p> <p>12 <b>out how to treat it.</b></p> <p>13 BY MR. KNOTT:</p> <p>14 Q She had three bowel obstruction surgeries</p> <p>15 resulting in colostomies. You're aware of that?</p> <p>16 MS. MAKAR: Same objections.</p> <p>17 <b>A Yes.</b></p> <p>18 BY MR. KNOTT:</p> <p>19 Q And that's -- the fact that she had three</p> <p>20 colostomies is not a factor you considered in</p> <p>21 assessing her life expectancy?</p> <p>22 MS. MAKAR: Same objection.</p> <p>23 <b>A Not a major one, no. It's baked in.</b></p> <p>24 BY MR. KNOTT:</p> <p>25 Q Do you agree, Doctor, that if you went to other</p>

<p style="text-align: right;">Page 82</p> <p>1 cardiologists to speak to them about their opinion</p> <p>2 on her life expectancy that the approach to</p> <p>3 assessing that would likely vary?</p> <p>4 MS. MAKAR: Objection. Form.</p> <p>5 Foundation.</p> <p>6 <b>A That's a very vague question, so I don't know what</b></p> <p>7 <b>you're asking.</b></p> <p>8 BY MR. KNOTT:</p> <p>9 Q If you went to talk to five cardiologists about</p> <p>10 this issue of her life expectancy, do you agree</p> <p>11 that there is likely to be multiple approaches to</p> <p>12 how to estimate that?</p> <p>13 MS. MAKAR: Same objection.</p> <p>14 <b>A If I were to approach other cardiologists, I would</b></p> <p>15 <b>ask them what of her chronic medical conditions or</b></p> <p>16 <b>problems are an acute threat to her life and how</b></p> <p>17 <b>does that factor in, and I'd have a conversation.</b></p> <p>18 <b>I don't think we would have a vast difference, but</b></p> <p>19 <b>there may be some difference.</b></p> <p>20 BY MR. KNOTT:</p> <p>21 Q Your report makes no reference to withdrawal from</p> <p>22 drugs or alcohol as contributing to the sequence</p> <p>23 of events. You don't hold an opinion that</p> <p>24 Ms. Boyer was experiencing withdrawal from drugs</p> <p>25 or alcohol, do you?</p>	<p style="text-align: right;">Page 84</p> <p>1 MR. KNOTT: Thank you.</p> <p>2 MR. JONES: I suggest we take a five- or</p> <p>3 10-minute break.</p> <p>4 MR. KNOTT: Sure. Okay by me.</p> <p>5 MS. MAKAR: Five or ten, Andrew?</p> <p>6 MR. JONES: Why don't we go for it.</p> <p>7 We'll take a 10-minute break. 12:25.</p> <p>8 MS. MAKAR: Okay.</p> <p>9 THE WITNESS: It's now 1:15.</p> <p>10 MR. JONES: 1:25, Doctor.</p> <p>11 THE WITNESS: Okay. Thank you.</p> <p>12 MR. JONES: Sure.</p> <p>13 (Brief recess taken from 12:15 p.m. to</p> <p>14 12:25 p.m.)</p> <p>15 E X A M I N A T I O N</p> <p>16 BY MR. JONES:</p> <p>17 Q Doctor, I'm Andrew Jones. I don't have all that</p> <p>18 many questions for you, but I do want to follow up</p> <p>19 on some things that you talked about with Mr.</p> <p>20 Knott.</p> <p>21 I am counsel for Monroe County and</p> <p>22 several of its correctional staff. Can you hear</p> <p>23 me okay?</p> <p>24 <b>A Yes, I can. Thank you.</b></p> <p>25 Q I thought I understood you to say during your</p>
<p style="text-align: right;">Page 83</p> <p>1 <b>A She might have been withdrawing from drugs or</b></p> <p>2 <b>alcohol. I don't know. But it doesn't change my</b></p> <p>3 <b>causation opinion that had she been sent to a</b></p> <p>4 <b>hospital in a timely manner she would have</b></p> <p>5 <b>survived.</b></p> <p>6 Q Then just let me wrap up that point.</p> <p>7 <b>A I thought I mentioned her narcotics, but maybe I</b></p> <p>8 <b>didn't. I thought I did.</b></p> <p>9 Q Doctor, can you state to a reasonable degree of</p> <p>10 medical probability that Ms. Boyer was</p> <p>11 experiencing withdrawal from drugs or alcohol on</p> <p>12 December 21st, 22nd or 23rd?</p> <p>13 <b>A I don't know.</b></p> <p>14 Q And so you cannot state to a reasonable degree of</p> <p>15 medical probability that she was experiencing</p> <p>16 withdrawal from alcohol?</p> <p>17 MS. MAKAR: Objection. Form.</p> <p>18 <b>A I don't know, and again, it doesn't affect my</b></p> <p>19 <b>causation opinion at all. That's a standard of</b></p> <p>20 <b>care issue, not a causation issue.</b></p> <p>21 MR. KNOTT: Doctor, I'm going to allow</p> <p>22 some of these other attorneys to ask questions and</p> <p>23 they'll introduce themselves. I'm going to look</p> <p>24 through my notes while they do that.</p> <p>25 THE WITNESS: Okay.</p>	<p style="text-align: right;">Page 85</p> <p>1 testimony that you don't know what caused</p> <p>2 Mrs. Boyer to code in the early morning hours of</p> <p>3 December 23rd; is that correct?</p> <p>4 <b>A Well, I don't know with enough -- I can say with</b></p> <p>5 <b>reasonable medical certainty that she developed a</b></p> <p>6 <b>spiral of high blood pressure, shortness of</b></p> <p>7 <b>breath, resulting in, and with her low potassium,</b></p> <p>8 <b>all conspiring to cause a cardiac arrest. I think</b></p> <p>9 <b>that's the most reasonable explanation with all</b></p> <p>10 <b>the medical facts.</b></p> <p>11 <b>So I can say with a reasonable</b></p> <p>12 <b>medical certainty, not absolute certainty, but</b></p> <p>13 <b>reasonable certainty that somewhere she developed</b></p> <p>14 <b>a spiral of chest pain -- I mean of high blood</b></p> <p>15 <b>pressure, which resulted in chest pain, shortness</b></p> <p>16 <b>of breath, and then because she had low potassium,</b></p> <p>17 <b>throwing her into an arrest. That's the most</b></p> <p>18 <b>likely explanation with all the facts we know.</b></p> <p>19 Q And are you offering that opinion in this case?</p> <p>20 <b>A Yes, but it's totally irrelevant to my main</b></p> <p>21 <b>opinion, which doesn't matter what she had. She</b></p> <p>22 <b>didn't die of it. She coded. So my main opinion</b></p> <p>23 <b>is if she were in a hospital, she would not be</b></p> <p>24 <b>dead.</b></p> <p>25 Q Okay. And I understand that you also are offering</p>

Page 86

1 that opinion. I just want to be clear on whether  
2 you're offering the opinion you just gave now in  
3 your last answer as to what caused her to code?

4 MS. MAKAR: Objection. Form.

5 **A I'm saying that I think it's with reasonable**  
6 **certainty the most likely explanation of what**  
7 **occurred. But it doesn't matter to my main**  
8 **causation opinion. It has nothing really to do**  
9 **with causation, only to the degree that she didn't**  
10 **die of something that was meant to kill her.**

11 Because you can -- for example, if  
12 someone said she had pneumonia, I think it's  
13 highly unlikely, but pneumonia kills you two ways;  
14 either major oxygen saturation drops, which never  
15 occurred here, someone's on 100 percent oxygen,  
16 you can't get any more in, they die, or they die  
17 of sepsis with low blood pressure. She didn't die  
18 of that. She didn't die of anything because her  
19 body recovered. It's her brain that was  
20 permanently damaged.

21 So no matter what triggered her  
22 arrest, ultimately that got better. The only  
23 thing we were left with was the brain damage,  
24 which was only a consequence of having such an  
25 event occur outside of a hospital. So that's my

Page 87

1 point.

2 So it really is not that important  
3 as to what I believe was the sequence of events  
4 that led to her arrest, but I think that is what  
5 most likely, in terms of causation, to have led to  
6 her arrest. I think it was related to her  
7 cardiomyopathy.

8 BY MR. JONES:

9 Q And if I understood the explanation you gave and  
10 offered in your report, it's her elevated blood  
11 pressure in combination with the underlying  
12 cardiomyopathy, that is, the reduced function of  
13 her left ventricle, and then with the low  
14 potassium level that caused her to have ischemia?

15 **A The low potassium had nothing to do with anything**  
16 **more than causing a torsades cardiac arrest.**  
17 **That's the electrical event caused by clinical**  
18 **events that triggered an electrical event.**

19 Q All right. Am I correct in understanding that  
20 you're saying, though, that the elevated blood  
21 pressure over the course of the afternoon in  
22 combination with the condition of her left  
23 ventricle caused her to have ischemia to some or  
24 all of the heart?

25 MS. MAKAR: Objection. Form.

Page 88

1 **A With reasonable certainty, it caused local**  
2 **ischemia in her inferior wall, because those are**  
3 **the leads that were affected. And I think that**  
4 **somehow the combination of all of that with the**  
5 **low potassium triggered the cardiac arrest.**

6 BY MR. JONES:

7 Q As a layperson, I understand ischemia to mean  
8 reduced blood flow to some portion of the heart;  
9 is that correct?

10 **A No. Ischemia means insufficient oxygen delivery**  
11 **for the work being demanded.**

12 The most common cause of ischemia  
13 is a blocked coronary artery with atherosclerosis  
14 with or without an acute blood clot, which can be  
15 an acute issue. But ischemia is any time there's  
16 a mismatch of supply and demand.

17 In this case, the demand for fuel  
18 goes up under stressed states, which would be  
19 included in a hypertensive episode as well as  
20 hypertension, and a low EF can lead to difficulty  
21 of blood getting through the muscle because the  
22 muscle is being stressed. So it's not the  
23 arteries themselves. So you can have both a  
24 reduction of supply and an increase in demand  
25 during such episodes, which can lead to chest pain

Page 89

1 and EKG changes.

2 Q So am I correct in understanding that the  
3 increased demand, that would be a function of the  
4 elevated blood pressure?

5 MS. MAKAR: Objection. Form.

6 **A Not that alone. The elevated blood pressure in**  
7 **conjunction with the cardiomyopathy. Either.**

8 BY MR. JONES:

9 Q And the cardiomyopathy, am I correct in  
10 understanding that that affects the ability of the  
11 heart to supply? I'm trying to understand what  
12 you say the mismatch between the supply and  
13 demand --

14 **A No. It's -- somehow I'm not obviously being very**  
15 **understandable, and I apologize for that. I don't**  
16 **know what I'm saying wrong.**

17 Q Well, it may be the listener, too. So...

18 **A It has to be me, because I usually can make things**  
19 **clear. Let me try one more time, and I apologize.**

20 If you have a combination of  
21 cardiomyopathy, some damage to someone's heart,  
22 left ventricle, and high blood pressure, makes  
23 them feel short of breath, they go into heart  
24 failure, that can lead to ischemia in the heart  
25 muscle through a number of mechanisms, one of

23 (Pages 86 to 89)

<p style="text-align: right;">Page 90</p> <p>1 which is the ventricle can stiffen under the</p> <p>2 setting of some high blood pressure, shortness of</p> <p>3 breath, which can in the muscle layer reduce blood</p> <p>4 flow through the muscle, because these arteries</p> <p>5 have to penetrate the muscle. So even though the</p> <p>6 big arteries are open, going through the muscle,</p> <p>7 it can tighten down on the small blood vessels</p> <p>8 leading to small vessel ischemia.</p> <p>9 Also, the work demand of the</p> <p>10 ventricle goes up when you have high blood</p> <p>11 pressure on top of a cardiomyopathy. So she had</p> <p>12 both reasons for -- and if she was withdrawing</p> <p>13 from drugs, it would certainly contribute to a</p> <p>14 spiral, but I don't know how much that was a role</p> <p>15 for her. All I can tell you is there was a</p> <p>16 spiral. Here's a lady who comes in with known</p> <p>17 heart disease. That's her only major systemic</p> <p>18 organ disease, who in the hospital has high blood</p> <p>19 pressure, which is cardiovascular, has chest pain</p> <p>20 which sounds cardiovascular, and she has an</p> <p>21 arrhythmia, which is cardiovascular. It's</p> <p>22 difficult to believe those are not all unified by</p> <p>23 the same cardiovascular process.</p> <p>24 Q Am I correct -- well, do you know the underlying</p> <p>25 cause of the cardiomyopathy?</p>	<p style="text-align: right;">Page 92</p> <p>1 so that's another favorable.</p> <p>2 Q Well, that was my next question. Am I correct in</p> <p>3 understanding you to say that she did not have</p> <p>4 congestive heart failure?</p> <p>5 A She did not have symptoms of congestive heart</p> <p>6 failure as a chronic issue. Her records show that</p> <p>7 she had no other symptoms. In November of 2019</p> <p>8 she was seen at her outpatient cardiology and they</p> <p>9 said no chest pain, no shortness of breath. And</p> <p>10 that's consistent with other visits.</p> <p>11 Q Well, do you understand her to have been diagnosed</p> <p>12 with congestive heart failure?</p> <p>13 A Well, again, congestive heart failure, some people</p> <p>14 just relate saying a low ejection fraction is</p> <p>15 congestive heart failure. But you really have to</p> <p>16 have congestive heart failure. She wasn't on a</p> <p>17 diuretic. She was on spiro lactone, which is a</p> <p>18 potassium sparing diuretic, but it wasn't like she</p> <p>19 was on Lasix. I didn't see evidence of that. I</p> <p>20 didn't see her needing to have fluid taken off,</p> <p>21 having leg edema, I don't see any volume overload.</p> <p>22 So I don't see any evidence of congestive heart</p> <p>23 failure, just she had a damaged ventricle.</p> <p>24 Q On your review of her medical history, she did not</p> <p>25 have any evidence of congestive heart failure; is</p>
<p style="text-align: right;">Page 91</p> <p>1 A It is unknown in her.</p> <p>2 Q I'm sorry?</p> <p>3 A It is unknown in her.</p> <p>4 Q Thank you.</p> <p>5 A It's called idiopathic, meaning they didn't know</p> <p>6 the reason.</p> <p>7 Q And the cardiomyopathy that she had, is that -- is</p> <p>8 there a way to characterize that in terms of being</p> <p>9 mild, moderate or severe?</p> <p>10 A Well, you can use kind of blunt terms with three</p> <p>11 categories, or you could just say she had an</p> <p>12 ejection fraction of, what was it, 40 to</p> <p>13 45 percent? I'm sorry. I forgot what her</p> <p>14 ejection fraction was. It was 35 to 40 percent.</p> <p>15 So she had an ejection fraction --</p> <p>16 normal ejection fractions range between 50 and 70.</p> <p>17 Most people are 60 percent, which means 60 percent</p> <p>18 of the blood gets squeezed out by the muscle when</p> <p>19 the heart beats. In her case only 35 to 40. So</p> <p>20 quantifying it is better than coming up with a</p> <p>21 general descriptor.</p> <p>22 Q If you had to put a general descriptor on it, what</p> <p>23 would it be?</p> <p>24 A Mild to moderate LV reduction. On the other hand,</p> <p>25 clinically, she was not in clinical heart failure,</p>	<p style="text-align: right;">Page 93</p> <p>1 that a correct statement?</p> <p>2 A I couldn't find any. Certainly not as a chronic</p> <p>3 issue, congestive heart failure.</p> <p>4 Q When -- what is the definition of coronary artery</p> <p>5 ischemia?</p> <p>6 A Well, it was a poor use of terms when I said it.</p> <p>7 Ischemia is ischemia, meaning not enough blood</p> <p>8 supplied for the demand for fuel. Usually when</p> <p>9 you say coronary ischemia, you're talking about a</p> <p>10 blocked coronary artery. But it was just poor --</p> <p>11 it was just sloppy language there. I was just</p> <p>12 using that as opposed to saying ischemia. But</p> <p>13 it's a poor term. She didn't have technically</p> <p>14 coronary artery ischemia. She had ischemia.</p> <p>15 Q So normally coronary artery ischemia would refer</p> <p>16 to a blockage, a reduced blood flow through the</p> <p>17 coronary artery?</p> <p>18 A Yes, usually that's what it means.</p> <p>19 Q I understood you to say that in between Friday and</p> <p>20 today you've reviewed the report of Dr. Wolff,</p> <p>21 Matthew Wolff?</p> <p>22 A Between Friday and today? I don't remember when I</p> <p>23 got it. It was recent, but I don't know if I got</p> <p>24 it Friday.</p> <p>25 Q Fair enough. That's my edition. I'll rephrase</p>

<p style="text-align: right;">Page 94</p> <p>1 it.</p> <p>2 Am I correct in understanding that</p> <p>3 you have reviewed the written report by Dr. Wolff?</p> <p>4 <b>A Yes, I have.</b></p> <p>5 Q And I understand you have it with you right there?</p> <p>6 <b>A I do.</b></p> <p>7 Q And just broadly speaking, are there any opinions</p> <p>8 offered by Dr. Wolff that you take issue with or</p> <p>9 disagreed with?</p> <p>10 <b>A There's only one thing he said in his report that</b></p> <p>11 <b>I take some issue with, but I think if we go</b></p> <p>12 <b>through his opinions, they all agree with me.</b></p> <p>13 <b>There's nothing in his report that varies from</b></p> <p>14 <b>what I said.</b></p> <p>15 <b>But he described her blood pressure</b></p> <p>16 <b>in what I think is a strange term. You can have</b></p> <p>17 <b>resistant hypertension, but he called her severe</b></p> <p>18 <b>multidrug resistant hypertension to make it sound</b></p> <p>19 <b>very severe.</b></p> <p>20 Q Can you -- I'm sorry. Can I just stop you briefly</p> <p>21 and have you point me to what -- what specifically</p> <p>22 you're referring to or just give me a page and</p> <p>23 line.</p> <p>24 <b>A Page 3 on the second half of the page, the second</b></p> <p>25 <b>paragraph under Brief Medical Summary, and he said</b></p>	<p style="text-align: right;">Page 96</p> <p>1 <b>with everything I said, or we're not in variance.</b></p> <p>2 <b>His main opinions that I think I can agree with is</b></p> <p>3 <b>that she had a primary ventricular arrhythmia.</b></p> <p>4 <b>Yes, I agree, although something may have</b></p> <p>5 <b>triggered it.</b></p> <p>6 <b>Two, it was precipitated by severe</b></p> <p>7 <b>low potassium. I agree, a significant</b></p> <p>8 <b>contributing factor. Three --</b></p> <p>9 Q Doctor, Doctor, if I may save you some time --</p> <p>10 <b>A Go ahead.</b></p> <p>11 Q -- other than his reference to her medical history</p> <p>12 having been notable for what he phrased as a</p> <p>13 severe multidrug resistant hypertension, is there</p> <p>14 any other portion of Dr. Wolff's written report</p> <p>15 that you disagree with?</p> <p>16 MS. MAKAR: Objection. Form.</p> <p>17 <b>A It's a little broad, because I haven't memorized</b></p> <p>18 <b>his report. I did review it. I don't remember</b></p> <p>19 <b>any major area of disagreement. But that doesn't</b></p> <p>20 <b>mean I'm blanketly saying I agree with every</b></p> <p>21 <b>sentence. I don't remember. There's no major</b></p> <p>22 <b>point that he brought up that I think requires me</b></p> <p>23 <b>to rebut. But somehow --</b></p> <p>24 BY MR. JONES:</p> <p>25 Q Well, he offered -- hang on. Bear with me. He</p>
<p style="text-align: right;">Page 95</p> <p>1 <b>here, "Her medical history was also notable for</b></p> <p>2 <b>severe multidrug resistant hypertension."</b></p> <p>3 <b>Now, we use kind of multidrug</b></p> <p>4 <b>resistant for antibiotics resistance. And there's</b></p> <p>5 <b>no evidence she had severe multidrug resistant</b></p> <p>6 <b>hypertension, because looking at her chart, she</b></p> <p>7 <b>was on the same drugs for hypertension for the</b></p> <p>8 <b>last eight years without even changing the doses.</b></p> <p>9 <b>And there were periods in 2017 where she had worse</b></p> <p>10 <b>high blood pressure, and it wasn't well</b></p> <p>11 <b>controlled, at least not perfectly controlled, but</b></p> <p>12 <b>there's no evidence of any drug resistance. It</b></p> <p>13 <b>wasn't like they were putting her on a new drug</b></p> <p>14 <b>every month and it kept failing. They never</b></p> <p>15 <b>changed her drugs.</b></p> <p>16 <b>So how do you say she is severe</b></p> <p>17 <b>multidrug resistant? All we see is she continued</b></p> <p>18 <b>to have hypertension despite her current medical</b></p> <p>19 <b>regimen. Doesn't mean she had any resistance. So</b></p> <p>20 <b>there was no increase in her drugs. There was no</b></p> <p>21 <b>addition. So it's just a bizarre thing to throw</b></p> <p>22 <b>into a report saying she had severe</b></p> <p>23 <b>multi-resistant hypertension. That's the only</b></p> <p>24 <b>small comment.</b></p> <p>25 <b>But otherwise, I think he agrees</b></p>	<p style="text-align: right;">Page 97</p> <p>1 offered seven numbered opinions in his report.</p> <p>2 Do you disagree with any of the</p> <p>3 seven numbered opinions that Dr. Wolff sets out in</p> <p>4 his report?</p> <p>5 MS. MAKAR: Objection. Form.</p> <p>6 <b>A Well, to begin with, he gave eight opinions</b></p> <p>7 <b>because he listed two different sixes. On Page 7,</b></p> <p>8 <b>he has two different opinion sixes, so I think he</b></p> <p>9 <b>has eight opinions, because Opinion 7 is actually</b></p> <p>10 <b>Opinion 8. Just --</b></p> <p>11 BY MR. JONES:</p> <p>12 Q With that clarification --</p> <p>13 <b>A With that clarification --</b></p> <p>14 Q -- let me --</p> <p>15 <b>A I want to go through and make sure -- I want to go</b></p> <p>16 <b>through and make sure I have them.</b></p> <p>17 Q Let me make sure that the question is on the</p> <p>18 record, though, Doctor, since we spoke over each</p> <p>19 other, and I will try not to do that.</p> <p>20 <b>A Sure.</b></p> <p>21 Q Of Dr. Wolff's eight numbered opinions, are there</p> <p>22 any that you disagree with?</p> <p>23 <b>A Well, I have to go through them to make sure. One</b></p> <p>24 <b>of them I don't have a comment on.</b></p> <p>25 <b>So one, he gives the opinion that</b></p>



<p style="text-align: right;">Page 98</p> <p>1 her arrest, No. 1 opinion, was due to a primary 2 arrhythmia, V-tach or V-fib. I agree with that. 3 Two, the ultimate fatal ventricular 4 arrhythmic arrest was precipitated by severe 5 hypokalemia, low potassium. I agree with that to 6 the degree that it was a significant contributing 7 factor. 8 And by the way, the arrhythmia 9 wasn't fatal. The neurologic injury due to the 10 fact this was out of hospital is what was fatal. 11 Three, her severe low potassium 12 predated her coming into the jail. I agree. 13 Four, her dilated cardiomyopathy 14 increased her vulnerability to a malignant 15 arrhythmia. I agree with that. 16 Seven -- I mean that was Opinion 17 No. 4. 18 Opinion No. 5, her cardiac arrest 19 was not due to an acute myocardial infarction, and 20 her chest complaints prior to arrest were not 21 secondary to coronary artery disease or 22 ventricular arrhythmias. 23 Well, technically I agree with him. 24 I think the patient was ischemic but not due to 25 coronary disease. I think that's the most likely</p>	<p style="text-align: right;">Page 100</p> <p>1 standard of care. He does, but I'm not offering 2 any. 3 And he didn't -- again, I just want 4 to make this clear. The main thrust of my opinion 5 is giving times by which if she had reached the 6 hospital the arrest would either have been 7 avoided, or if not avoided, would have been 8 resuscitated without brain damage. And from my 9 reading of every defense expert who's seen my 10 report, I presume, no one has disagreed with that 11 including Dr. Wolff. So -- 12 Q And in -- 13 A -- to that degree, I agree with him. 14 Q And picking up on what you said in reference to 15 his -- what he labels as Opinion 7 on Page 8 of 16 his report. You made the observation in your 17 report on Page 3, "the correctional staff 18 responded aggressively and appropriately once 19 Ms. Boyer suffered her cardiac arrest." 20 Do you recall that observation in 21 your report? 22 A Although -- yeah, I'm supportive of them, but I'm 23 still not going to be offering standard of care. 24 Q I understand. But you made the observation in 25 your report, correct?</p>
<p style="text-align: right;">Page 99</p> <p>1 answer. And her chest pain was because of the 2 hypertension and underlying heart disease. And I 3 agree she didn't have an acute MI either, so in 4 principle we're not very far apart on Opinion 5. 5 Opinion 6, the cardiac arrest was 6 not due to malignant hypertension. I agree with 7 that. No one ever said she had malignant 8 hypertension. It was never suggested. I never 9 said she had malignant hypertension. 10 Opinion 6, which is actually 11 Opinion 7, the medical care provided to Ms. Boyer 12 was reasonable, consistent with accepted medical 13 standards. I'm not offering a standard of care 14 opinion. 15 And then his final opinion, the 16 initial care she received from jail personnel 17 following her cardiac arrest was timely -- yeah. 18 When she coded, they did the best they could. I'm 19 not -- and I'm not giving standard of care, but I 20 agree that at least the code -- I have -- it's a 21 standard of care opinion. I haven't seen 22 anyone -- I don't recall anyone raising a 23 criticism of the post-arrest, of the arrest 24 management, you know, but I'm not giving any 25 opinion about that. So I have no opinion on</p>	<p style="text-align: right;">Page 101</p> <p>1 A Yes. 2 MS. MAKAR: Objection. Form. 3 BY MR. JONES: 4 Q And do you stand by that observation in your 5 report? 6 MS. MAKAR: Objection. Form. 7 A Yes. Of course I do. 8 BY MR. JONES: 9 Q Were there any -- were there any pieces of 10 literature in your field or any other sources from 11 your field that you relied on in forming or 12 reaching your opinions? 13 A No. 14 Q I'm sorry. I didn't hear your answer. 15 A No. 16 Q And I assume the list of records that you provided 17 on Page 1 and 2 of your report and that you 18 reviewed, is that a complete list of all the 19 records you reviewed in forming your opinions? 20 A Yes. Obviously they don't include the defense 21 reports, which came later, but yes. 22 Q Understood. And were there any records that you 23 asked for but that you were not provided? 24 A No. 25 Q You've provided us with the invoices that you gave</p>



Page 102

1 to the Loevy firm for your work in this case,  
 2 correct?  
 3 **A Yes.**  
 4 Q And were there any other written communications  
 5 between you and Ms. Makar or anybody else at the  
 6 Loevy firm relating to your compensation for your  
 7 work in this matter?  
 8 **A No.**  
 9 Q And were there any --  
 10 **A No.**  
 11 Q Were there any written communications coming from  
 12 Ms. Makar or anyone else at the Loevy firm to you  
 13 that identified specific facts or data that you've  
 14 relied on in forming your opinions?  
 15 **A No. No. Nothing.**  
 16 Q And were there any written communications from  
 17 Ms. Makar or anyone else at her firm to you  
 18 identifying assumptions that you relied on in  
 19 forming your opinions?  
 20 **A No. No. Absolutely not.**  
 21 Q And the invoices that you've provided Mr. Knott,  
 22 marked them as Exhibit 118, the last invoice is  
 23 dated January 22nd, 2025. Do you recall that?  
 24 **A That's the final invoice.**  
 25 Q So as of last Wednesday, I believe that is, do

Page 103

1 those invoices account for all of the hours you've  
 2 spent in connection with your work on this matter  
 3 up through January 22nd of 2025?  
 4 THE STENOGRAPHER: Yes?  
 5 **A I said "yes."**  
 6 BY MR. JONES:  
 7 Q I didn't -- thank you.  
 8 And if I can just ask you about the  
 9 last one from last Wednesday, January 22nd, the  
 10 narrative on the invoice reads that you were  
 11 billing for upcoming review of defense reports,  
 12 preparation for your deposition, and the  
 13 anticipated pre-deposition discussion with  
 14 counsel.  
 15 **A Yes.**  
 16 Q So am I correct in understanding this invoice was  
 17 sort of anticipatory of that work?  
 18 **A Yes. I knew there'd be an hour discussion, that's**  
 19 **typical. We were about an hour. I was given the**  
 20 **understanding there'd be a handful of reports. So**  
 21 **that's factored in, and my final prep, so yes.**  
 22 Q Okay. And so does that invoice essentially  
 23 account for the time you spent in preparing for  
 24 the deposition?  
 25 **A Correct.**

Page 104

1 Q So in truth, these invoices account for all of the  
 2 time you spent on this file up until the moment we  
 3 began this deposition this morning; is that  
 4 correct?  
 5 **A Yes, that is correct.**  
 6 Q And is \$550 an hour -- well, scratch that.  
 7 **A It went up to 600 an hour last year.**  
 8 Q Yeah, I just noticed that.  
 9 **A 2023 it went up to 600 an hour.**  
 10 Q Okay. So 600 an hour, is that your standard rate  
 11 for your work as an expert witness?  
 12 **A For review. For deposition it's \$700 an hour**  
 13 **because that cuts into my daytime, which I can**  
 14 **review at night. And then for trial, if it's out**  
 15 **of town, I charge \$6,000 for the day plus**  
 16 **reasonable expenses. I don't charge for travel**  
 17 **time. Just the day of being gone.**  
 18 Q And previously was the standard rate for review  
 19 and report writing 550, was that your standard  
 20 rate?  
 21 **A No. Then it was 550 for review, 600 for**  
 22 **testimony, and 5,000 for day at trial.**  
 23 Q I'm not asking you very good questions. Let me  
 24 try with a different question.  
 25 The rates that you've charged the

Page 105

1 Loevy firm for your work in this matter, have  
 2 those been your standard billing rates?  
 3 **A Well, since I've made the change, yes. It's not**  
 4 **special for them. Those are my rates.**  
 5 Q Were there any materials you reviewed to prepare  
 6 for the deposition, other than your report, the  
 7 reports by the other experts that you've been  
 8 provided or records that are identified on pages 1  
 9 and 2 of your report?  
 10 **A I'm sorry. When did you ask? I missed that, the**  
 11 **first part. I couldn't hear it.**  
 12 Q Were there any records you reviewed to prepare for  
 13 your deposition, other than your own report, the  
 14 reports of the other experts that Ms. Makar  
 15 provided you?  
 16 **A No. I relooked at the Gundersen records.**  
 17 Q So anything other than your report, the Gundersen  
 18 records and the other expert reports that you were  
 19 provided?  
 20 **A Well, the defense reports, of course, I spent a**  
 21 **fair amount of time with those, going over their**  
 22 **dissertations. So those were the major things was**  
 23 **my report, defense reports, and the Gundersen**  
 24 **file.**  
 25 Q Was there anything else you reviewed to prepare

27 (Pages 102 to 105)

Page 106

1 for your deposition?

2 **A I looked at some of the jail records again,**

3 **although I mean, not extensively, but I did spend**

4 **time looking at the narrative reports of the jail.**

5 Q Anything else?

6 **A No, not that I can think of.**

7 Q You're licensed in New York, correct?

8 **A Yes.**

9 Q Have you ever been licensed in a state other than

10 New York?

11 **A No.**

12 Q Have you ever been subject to any sort of

13 discipline under your New York license or your

14 board certification?

15 **A I've had no discipline outside of marriage. A**

16 **little levity into today's proceedings. I'm**

17 **sorry.**

18 Q That's good. That's good.

19 And your CV, it includes all of

20 your publications, correct?

21 **A Yes.**

22 Q I'm sorry. I didn't hear an answer.

23 **A I said "yes."**

24 MR. JONES: Okay. Thank you, Doctor.

25 THE WITNESS: Certainly, sir.

Page 107

1 EXAMINATION

2 BY MR. CASSERLY:

3 Q Hi, Doctor. I think I'm only going to be going

4 about five minutes, so if you need a break, we can

5 take one, otherwise I can just charge ahead.

6 **A I think we should just charge ahead.**

7 Q Great. I hear no objection. So I'll introduce

8 myself. My name's John Casserly. I am an

9 attorney for some defendants in this matter. They

10 are USA Medical and Psychological Staffing, S.C.,

11 and four doctors, Drs. Harmston, Bresnahan,

12 Johnson and Schamber.

13 And I assure you, I was listening

14 when you told Mr. Knott that your opinions are in

15 your report and you're not intending to give any

16 other opinions, and because of that, I will

17 shorten these up. But I do need to confirm,

18 because there are some allegations in this case

19 about my clients that are not explicitly medical,

20 but I need to make sure you're not going to have

21 an opinion on them.

22 So my first question is, you have

23 not reviewed the deposition transcripts of any of

24 the corporate officers or shareholders of the --

25 of USA Medical and ACH. Those would be

Page 108

1 Dr. Johnson, and CEO Jessica Young, and CFO Jaime

2 Lynch, right?

3 **A Correct.**

4 Q And is it fair to say that you don't have an

5 opinion about the corporate structure or the

6 corporate financial status of USA Medical or

7 Advanced Correctional Healthcare; is that right?

8 **A That is correct.**

9 Q Okay. You don't have any criticisms that those

10 corporations are under -- underinsured or

11 undercapitalized; is that right?

12 **A No, I have no opinions about anything to do with**

13 **the corporate structure or finance or anything**

14 **like that. I will not talk about them for a**

15 **millisecond.**

16 MR. CASSERLY: All right. You have --

17 you have exhausted my questions. I have no

18 others.

19 THE WITNESS: Okay. Mr. Knott, do you

20 have any further questions, or did you --

21 MR. KNOTT: Yeah, I just need to follow

22 up. Thank you, Doctor.

23 EXAMINATION

24 BY MR. KNOTT:

25 Q You said that you had reviewed the report of

Page 109

1 Pearson. Ms. Pearson is a nurse. I assume you

2 have no commentary or debate with Ms. Pearson that

3 you --

4 **A I have no opinion about her standard of care**

5 **opinions.**

6 MS. MAKAR: I --

7 BY MR. KNOTT:

8 Q Yeah. And the same with respect to Dr. Young, do

9 you have any -- did that alter your opinions or do

10 you wish to add to your opinions in this case

11 because of your review of Dr. Young's report?

12 MS. MAKAR: Sorry. Go ahead. Finish.

13 MR. KNOTT: I did.

14 **A I think --**

15 MS. MAKAR: Oh. I would just object to

16 any questioning outside of the scope of John or

17 Andrew's questioning, as you've passed the

18 witness, and move to strike any question in

19 response, outside the scope of that questioning

20 under Rule 30.

21 **A Anyway, I have no comment on their opinions. They**

22 **did not in any way address my causation opinion,**

23 **so we have no overlap. I'm not agreeing or**

24 **disagreeing with anything they say. We just don't**

25 **have any overlap.**

28 (Pages 106 to 109)

Page 110

1 BY MR. KNOTT:  
 2 Q Okay. Doctor, is it your opinion that Ms. Boyer's  
 3 experience of chest pain was due to ischemia, or  
 4 can you not know?  
 5 A **I think with medical certainty she was**  
 6 **experiencing some ischemia, because you have**  
 7 **underlying heart disease, you had her having chest**  
 8 **pain and shortness of breath going on to a cardiac**  
 9 **arrest and having ischemic abnormalities on her**  
 10 **first EKG after the arrest. So I would say with a**  
 11 **reasonable medical certainty she was experiencing**  
 12 **some form of ischemia right before her arrest.**  
 13 Q And are you -- the question is a little different.  
 14 Are you testifying that her  
 15 experience of chest pain during the day or evening  
 16 was caused by heart ischemia?  
 17 A **I said it would likely be ischemia. I've said**  
 18 **that.**  
 19 Q Okay. I understand you to say there was likely  
 20 ischemia, but the question is whether at that  
 21 particular time you thought -- you think that the  
 22 pain she experienced was resulting from ischemia,  
 23 or can you not know with that specificity?  
 24 MS. MAKAR: Objection.  
 25 A **I'm saying I think her chest pain was, within**

Page 111

1 **reasonable medical certainty, more likely than not**  
 2 **to be ischemic pain. Am I not understanding what**  
 3 **you're asking me? Am I answering you? I really**  
 4 **don't want to be rude. I thought that was my**  
 5 **answer. I think with reasonable certainty she was**  
 6 **feeling chest pain from coronary -- from cardiac**  
 7 **ischemia.**  
 8 BY MR. KNOTT:  
 9 Q Your response ended with before her --  
 10 A **Okay. Then take that back. That's fine. Her**  
 11 **chest pain was ischemia pain with reasonable**  
 12 **certainty.**  
 13 MR. KNOTT: Okay. Okay. Those are the  
 14 questions I have. Thank you.  
 15 THE WITNESS: Okay.  
 16 MS. MAKAR: I don't have any questions.  
 17 Thank you, Doctor.  
 18 THE WITNESS: You're welcome. I will  
 19 send you an invoice for the three hours of this  
 20 deposition which you can forward to the defense,  
 21 Maria?  
 22 MS. MAKAR: Yes.  
 23 THE WITNESS: And a W9 as well. Okay.  
 24 MS. MAKAR: Yes.  
 25 THE WITNESS: Are you in read or waive

Page 112

1 kind of thing? Do you do that when you have  
 2 depositions in your state? Some states I have to  
 3 read or waive.  
 4 MS. MAKAR: Yes, I think you're about to  
 5 be asked that.  
 6 THE WITNESS: Okay. Then I'll read.  
 7 Thank you. You all take care.  
 8 (Deposition concluded at 1:05 p.m.)  
 9 (Deposition Exhibit Nos. 117 through 122  
 10 electronically marked for identification.)  
 11 (Original exhibits attached to Original  
 12 transcript; copies of exhibits are attached.)  
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Page 113

1 STATE OF WISCONSIN )  
 2 ) SS:  
 3 MILWAUKEE COUNTY )  
 4 I, Rosanne E. Pezze, RPR/CSR/CRR  
 5 and Notary Public in and for the State of  
 6 Wisconsin, do hereby certify that the deposition  
 7 of BRUCE CHARASH, M.D. was recorded remotely by me  
 8 and reduced to writing under my personal  
 9 direction.  
 10 I further certify that said  
 11 deposition was taken remotely from New York City,  
 12 New York, on the 28th day of January, 2025,  
 13 commencing at 10:04 a.m.  
 14 I further certify that I am not a  
 15 relative or employee or attorney or counsel of any  
 16 of the parties, or a relative or employee of such  
 17 attorney or counsel, or financially interested  
 18 directly or indirectly in this action.  
 19 In witness whereof, I have hereunto  
 20 set my hand and affixed my seal of office on this  
 21 3rd day of February, 2025.  
 22  
 23  
 24 ROSANNE E. PEZZE, RPR/CSR/CRR  
 25 Notary Public  
 My commission expires January 10, 2026

29 (Pages 110 to 113)

Page 114

1 STATE OF WISCONSIN )  
2 ) SS:  
3 MILWAUKEE COUNTY )  
4  
5  
6

7 I, BRUCE CHARASH, M.D., do hereby certify  
8 I have read the foregoing transcript of proceedings  
9 taken January 28th, 2025, remotely from New York  
10 City, New York, and the same is true and  
11 correct except for the list of corrections noted on  
12 the annexed page.  
13  
14  
15

16 Dated at \_\_\_\_\_  
17 this \_\_\_\_\_ day of \_\_\_\_\_, 2025.  
18  
19

20 \_\_\_\_\_  
21 BRUCE CHARASH, M.D.  
22  
23  
24  
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30 (Page 114)

<b>A</b>	<b>ACH</b> 2:20	27:24 28:1	<b>annexed</b> 114:12	40:15
<b>a.m</b> 1:19 2:9	107:25	<b>affixed</b> 113:20	<b>annual</b> 18:10	<b>appropriately</b>
40:3,4 113:13	<b>ACLS</b> 60:17	<b>AFib</b> 68:6	<b>answer</b> 21:18	100:18
<b>abdomen</b> 37:10	<b>action</b> 2:2	<b>afternoon</b> 44:13	23:5 40:21	<b>appropriateness</b>
77:21	113:18	45:10,19 62:14	73:19 79:19	40:19,20
<b>abdominal</b>	<b>active</b> 31:19	87:21	86:3 99:1	<b>approximate</b>
36:23 37:9	43:22	<b>again/off</b> 68:24	101:14 106:22	18:24 19:7
77:16	<b>actively</b> 12:16	<b>aggressively</b>	111:5	<b>approximately</b>
<b>Aberdeen</b> 2:14	<b>acute</b> 27:5 34:13	100:18	<b>answering</b> 111:3	6:16 9:4 15:18
<b>ability</b> 89:10	43:13,14 44:10	<b>ago</b> 12:9,25	<b>antibiotics</b> 95:4	16:1 36:13
<b>able</b> 21:4 51:1	44:15,22 48:1	<b>agree</b> 33:24 34:2	<b>anticipated</b>	<b>April</b> 29:22
53:21 54:24	59:8 82:16	36:11 40:14	103:13	<b>area</b> 5:12 96:19
66:23 77:22	88:14,15 98:19	42:13 48:12	<b>anticipatory</b>	<b>areas</b> 31:9
<b>abnormal</b> 56:22	99:3	52:6 55:12	103:17	<b>argue</b> 74:19
64:13	<b>acutely</b> 34:16	56:2 59:3,14	<b>anxiety</b> 46:18,22	<b>argument</b> 60:7
<b>abnormalities</b>	<b>add</b> 7:15,17	60:11 61:5	47:8	<b>arm</b> 46:6 51:5
44:6 46:8,11	75:21 109:10	66:13 67:25	<b>anybody</b> 102:5	<b>arrest</b> 27:6,7
46:15 79:6	<b>add-on</b> 47:21	70:2 81:25	<b>anymore</b> 17:2	31:9 44:19,20
110:9	<b>addition</b> 16:11	82:10 94:12	17:14 21:7	46:12 48:5
<b>abnormality</b>	95:21	96:2,4,7,20	43:10	51:16 55:11,12
58:14	<b>address</b> 6:8,9,11	98:2,5,12,15	<b>anyone's</b> 19:24	60:15,21 62:2
<b>above-entitled</b>	109:22	98:23 99:3,6	<b>Anyway</b> 109:21	62:12,24 63:1
2:2	<b>addressing</b> 6:2	99:20 100:13	<b>apart</b> 99:4	63:25 67:6,8
<b>absolute</b> 20:11	<b>adequacy</b> 23:22	<b>agreeing</b> 109:23	<b>apologize</b> 24:25	68:13,15,19,25
42:5 45:21	<b>administration</b>	<b>agrees</b> 49:14	25:4 29:11	81:9 85:8,17
63:13 67:14	40:15	95:25	31:11 49:19	86:22 87:4,6
85:12	<b>Administrator</b>	<b>ahead</b> 96:10	89:15,19	87:16 88:5
<b>absolutely</b> 19:17	1:3,10	107:5,6 109:12	<b>apparent</b> 34:12	98:1,4,18,20
37:20 39:24	<b>admission</b> 61:5	<b>air</b> 38:10 39:7	<b>apparently</b>	99:5,17,23
81:11 102:20	72:12	<b>al</b> 1:7,14	37:24	100:6,19 110:9
<b>abstracts</b> 32:10	<b>admissions</b>	<b>albeit</b> 46:8	<b>appear</b> 33:24	110:10,12
<b>abuse</b> 79:1	27:14	<b>alcohol</b> 39:8	34:3	<b>arrested</b> 53:17
<b>academic</b> 25:21	<b>admit</b> 28:13	82:22,25 83:2	<b>appeared</b> 2:16	64:11
26:25 28:2	<b>admitted</b> 42:22	83:11,16	2:20 3:5,10	<b>arrhythmia</b> 34:1
30:11,12	43:3 44:21	<b>Alecia</b> 3:13	7:11,12 33:19	53:7,10 54:4
<b>accent</b> 55:24	46:12 60:9	<b>allegations</b>	<b>appearing</b> 1:20	60:12,24 66:14
56:1	74:12	107:18	2:7	67:5 68:2,5,8
<b>accept</b> 35:11	<b>advanced</b> 1:7	<b>allow</b> 83:21	<b>appointment</b>	90:21 96:3
<b>accepted</b> 34:18	23:22 24:8	<b>alter</b> 109:9	28:3	98:2,8,15
99:12	25:6 38:7	<b>Amber</b> 2:20	<b>appointments</b>	<b>arrhythmias</b>
<b>access</b> 11:2,3	108:7	<b>amount</b> 105:21	25:22	53:13,16 68:6
17:10	<b>advances</b> 27:7	<b>analyze</b> 20:2	<b>appreciate</b> 23:5	68:7 98:22
<b>account</b> 103:1	<b>advice</b> 32:19	<b>anatomic</b> 44:7	23:5 64:6	<b>arrhythmic</b> 98:4
103:23 104:1	<b>affect</b> 78:11	<b>Andrew</b> 3:8 84:5	<b>approach</b> 82:2	<b>arteries</b> 64:18
<b>accurate</b> 15:16	83:18	84:17	82:14	64:24 75:24
15:24	<b>affiliated</b> 17:18	<b>Andrew's</b>	<b>approaches</b>	88:23 90:4,6
<b>accurately</b> 56:3	26:1 27:25	109:17	82:11	<b>artery</b> 45:25
	<b>affiliation</b> 27:21	<b>angle</b> 32:16	<b>appropriate</b>	62:17,21 64:23

65:2,8 88:13 93:4,10,14,15 93:17 98:21 <b>asked</b> 6:14 7:15 9:16 16:10 20:14 22:8 35:16,17,20 50:3 101:23 112:5 <b>asking</b> 48:15,18 48:19 54:16 82:7 104:23 111:3 <b>aspect</b> 22:19 <b>assessing</b> 80:2 81:21 82:3 <b>assessment</b> 38:12 64:1 74:5 76:1 <b>assigned</b> 26:14 26:16 <b>assistant</b> 26:5 <b>associated</b> 57:12 57:13 <b>assume</b> 13:7 66:3 67:19 101:16 109:1 <b>assumptions</b> 102:18 <b>assure</b> 107:13 <b>asthma</b> 77:25 78:8,11 <b>asymptomatic</b> 75:2 <b>atherosclerosis</b> 65:8 88:13 <b>attached</b> 4:18,18 112:11,12 <b>attacks</b> 45:25 56:20 <b>attending</b> 16:19 27:17 28:14,20 29:19,22 <b>attention</b> 47:20 <b>attorney</b> 107:9 113:15,17 <b>attorneys</b> 83:22 <b>authorized</b> 18:4	<b>autopsy</b> 64:18 76:7 80:15 <b>available</b> 78:15 78:19 <b>Avenue</b> 2:18 <b>average</b> 7:1,11 17:25 18:1 71:12,19 72:3 72:4,6,7,7 73:23 76:12,13 78:5,12 <b>averaging</b> 24:18 24:20 <b>aVF</b> 44:2 55:5 <b>aVL</b> 55:6 <b>avoid</b> 32:24 <b>avoided</b> 100:7,7 <b>aware</b> 11:24 25:23 38:17 68:17,21,23 69:1 79:8 80:17 81:15 <hr/> <b>B</b> <b>B</b> 3:2 4:9 <b>back</b> 6:6 7:9 19:3 20:18 26:6 60:20 111:10 <b>Background</b> 36:18 <b>bad</b> 32:22 <b>baked</b> 72:4 74:4 76:4,11,19,22 78:4,12,23 81:23 <b>based</b> 5:22 6:23 6:24 15:25 18:11 64:1 <b>baseline</b> 43:19 <b>basis</b> 38:10,23 41:2 62:20 66:5,11 70:18 <b>Bates</b> 4:15,16 10:10 <b>bathroom</b> 39:21 <b>bear</b> 14:14 21:9 96:25	<b>beats</b> 91:19 <b>becoming</b> 31:22 <b>bed</b> 65:15 <b>began</b> 104:3 <b>beginning</b> 43:18 <b>begins</b> 54:20,21 62:7 <b>behalf</b> 1:4,11 2:16,20 3:5,10 21:14 <b>believe</b> 8:12 22:11,14 36:20 42:19 45:16 52:11 54:25 87:3 90:22 102:25 <b>believed</b> 15:14 69:12 <b>best</b> 63:10,20 99:18 <b>better</b> 86:22 91:20 <b>beyond</b> 80:20 <b>big</b> 18:2 27:3 48:6 90:6 <b>biggest</b> 25:25 <b>bill</b> 18:4,20 <b>billing</b> 103:11 105:2 <b>bit</b> 47:18 76:4 <b>bizarre</b> 95:21 <b>blanketly</b> 96:20 <b>block</b> 48:21 <b>blockage</b> 93:16 <b>blocked</b> 88:13 93:10 <b>blocking</b> 46:1 <b>blood</b> 41:16,18 41:22,25 42:7 46:1,18,24 50:10,13,17,20 52:3 63:2,14 63:17 65:4,12 67:10 69:11 85:6,14 86:17 87:10,20 88:8 88:14,21 89:4 89:6,22 90:2,3	90:7,10,18 91:18 93:7,16 94:15 95:10 <b>blow</b> 54:13 <b>blue</b> 67:9 <b>blunt</b> 91:10 <b>board</b> 106:14 <b>body</b> 86:19 <b>book</b> 32:15 33:3 <b>bottom</b> 55:20 <b>bowel</b> 77:20 81:14 <b>Boyer</b> 1:3,4,10 1:11 8:1 24:9 33:21 38:15 40:13 45:8,18 75:18,18 76:21 80:16 82:24 83:10 85:2 99:11 100:19 <b>Boyer's</b> 110:2 <b>brain</b> 33:25 51:17 64:12,13 86:19,23 100:8 <b>break</b> 10:14 39:21,23 49:15 71:16 84:3,7 107:4 <b>breath</b> 39:12,19 42:7 46:6,20 47:2,8,11 51:6 52:2 61:17,19 63:2,19 72:13 74:13 85:7,16 89:23 90:3 92:9 110:8 <b>breathe</b> 39:17 39:18 <b>breathing</b> 34:15 39:12,15,16 <b>Bresnahan</b> 3:6 107:11 <b>brief</b> 40:3 49:1 84:13 94:25 <b>briefly</b> 23:8 94:20 <b>bring</b> 27:13 <b>brings</b> 47:19	<b>broad</b> 96:17 <b>broadly</b> 94:7 <b>Broadway</b> 3:8 <b>broken</b> 35:15 <b>brought</b> 96:22 <b>Bruce</b> 1:17 2:1 4:12,13,14 5:2 5:9 113:7 114:7,21 <b>bunch</b> 33:2 <b>burning</b> 74:15 <b>bursts</b> 66:17 <hr/> <b>C</b> <b>C</b> 2:12 3:1 <b>C-H-A-R-A-S...</b> 5:9 <b>calendar</b> 15:11 <b>call</b> 18:12 19:19 27:11 28:25 29:3,7,8,13,14 43:25 <b>called</b> 22:6,22 25:24 27:9,12 28:20 30:6,8 32:15 43:16 91:5 94:17 <b>calls</b> 18:18 <b>cancer</b> 36:24 37:11 38:7 70:4 72:1 76:6 76:7 77:19 80:14 <b>capital</b> 32:5,6 <b>captured</b> 53:11 <b>cardiac</b> 16:14 27:6,7 30:24 31:8 44:19 46:12 47:11 48:4 50:17 51:16 52:18 60:15 62:2,12 62:24 68:25 85:8 87:16 88:5 98:18 99:5,17 100:19 110:8 111:6 <b>cardiologist</b>
---	---	---	--	---



16:8,16 54:25 <b>cardiologists</b> 17:21 29:18,20 82:1,9,14 <b>cardiology</b> 5:13 16:10,12 26:22 27:17 28:19,21 29:14 92:8 <b>cardiomyopat...</b> 59:17 <b>cardiomyopat...</b> 44:16 49:25 50:8,13,19 58:11 72:11 74:15,21,23,25 75:1,6 87:7,12 89:7,9,21 90:11,25 91:7 98:13 <b>cardiovascular</b> 69:14 90:19,20 90:21,23 <b>care</b> 16:11,13 17:22 23:3,7 23:20 24:4,7 27:19 30:25 36:7 40:17,24 47:14 48:15 52:8 83:20 99:11,13,16,19 99:21 100:1,23 109:4 112:7 <b>cared</b> 37:20 <b>case</b> 1:6,13 6:5 8:1 10:1,25 11:19,22 12:8 12:11,14,19 13:5,15 14:7,9 14:10,25 17:13 17:13 19:23 20:2,23 21:13 22:7,18,20 24:5 25:3,15 27:1 33:9 46:5 63:19,23 71:7 73:2 74:3 85:19 88:17 91:19 102:1	107:18 109:10 <b>cases</b> 7:8 10:1,21 13:10 14:2,5 15:17,21 19:5 19:9,10,18,19 20:5,9,10,10 20:12,15,16 21:13 22:5,8 24:15 47:22,23 <b>Casserly</b> 3:2 4:5 107:2,8 108:16 <b>casually</b> 42:3 <b>categories</b> 91:11 <b>cath</b> 55:14 <b>catheterization</b> 19:21 <b>causation</b> 22:23 23:1,7 36:9 40:18 44:17 48:8 49:8 63:6 83:3,19,20 86:8,9 87:5 109:22 <b>cause</b> 44:23 53:10 58:15 61:12,16,17,20 68:15 70:5 73:10 80:12 85:8 88:12 90:25 <b>caused</b> 51:14,17 51:18,24 69:24 80:11 85:1 86:3 87:14,17 87:23 88:1 110:16 <b>causes</b> 61:19 <b>causing</b> 69:12 70:1 87:16 <b>CCTV</b> 33:6 <b>CDC</b> 71:1,5 72:18 73:2,9 73:20 74:4 75:4 <b>cell</b> 18:16 <b>Center</b> 31:7 <b>CEO</b> 108:1 <b>certain</b> 6:23	32:22 44:17 46:3 57:13 <b>certainly</b> 57:2 75:21,21 81:4 90:13 93:2 106:25 <b>certainty</b> 45:21 63:12,13,14 67:14,15 81:7 85:5,12,12,13 86:6 88:1 110:5,11 111:1 111:5,12 <b>certification</b> 106:14 <b>Certified</b> 1:24 2:6 <b>certify</b> 113:6,10 113:14 114:7 <b>CFO</b> 108:1 <b>challenged</b> 49:7 <b>challenging</b> 27:13 <b>chance</b> 68:4 <b>change</b> 43:13 44:24 83:2 105:3 <b>changed</b> 17:20 25:19 95:15 <b>changes</b> 25:13 43:14 45:5 89:1 <b>changing</b> 95:8 <b>characterize</b> 14:7 41:12 42:10 91:8 <b>Charash</b> 1:17 2:1 4:12,13,14 5:2,9,14 9:22 113:7 114:7,21 <b>charge</b> 18:14 104:15,16 107:5,6 <b>charged</b> 104:25 <b>chart</b> 95:6 <b>chat</b> 9:3,4,7,9,11 <b>check</b> 63:16 <b>chest</b> 27:5 31:7	34:20,22 36:15 42:7 45:10,18 46:5,15,19,22 47:1,7,10,14 47:19 48:2,16 51:5 52:2,18 61:12,13,16,20 63:2,18 67:11 68:23 69:13 85:14,15 88:25 90:19 92:9 98:20 99:1 110:3,7,15,25 111:6,11 <b>Chicago</b> 2:14 <b>chief</b> 30:24 31:1 31:2,8 <b>childhood</b> 70:3 <b>choice</b> 20:1 <b>Christine</b> 1:4,11 8:1 24:9 <b>chronic</b> 51:1 70:7 72:16 77:10 79:23 82:15 92:6 93:2 <b>cigarette</b> 76:9 79:7 <b>City</b> 1:20 2:8 113:11 114:10 <b>civil</b> 2:4 22:13 22:17,20 <b>claims</b> 22:12 <b>clarification</b> 97:12,13 <b>clarify</b> 28:10 29:9 <b>Class</b> 72:13 <b>classic</b> 44:6 <b>clean</b> 75:23 <b>clear</b> 7:21 25:2 29:25 60:21 66:1 86:1 89:19 100:4 <b>clearly</b> 44:21 <b>clicks</b> 12:4 <b>client</b> 25:3 <b>clients</b> 107:19	<b>clinical</b> 26:5,20 26:25 27:18 33:22 74:9 87:17 91:25 <b>clinically</b> 69:12 79:5 91:25 <b>clonidine</b> 40:13 40:15,20 52:4 69:2 <b>close</b> 9:6 36:8 <b>closed</b> 62:17 <b>clot</b> 45:25 65:9 88:14 <b>coast</b> 15:21,22 <b>code</b> 46:8,16 51:12,14,15,19 51:24 59:7,8 59:10,11 85:2 86:3 99:20 <b>coded</b> 51:12,21 52:14 64:9 68:5 85:22 99:18 <b>coding</b> 51:9 <b>cohort</b> 71:9 <b>cold</b> 14:17 39:22 39:22 <b>collapsed</b> 33:21 <b>colostomies</b> 81:15,20 <b>column</b> 13:13 <b>combination</b> 87:11,22 88:4 89:20 <b>come</b> 19:18 27:10 31:5 45:3 <b>comes</b> 19:11 28:15,17 90:16 <b>comfortable</b> 34:15 42:9,11 <b>coming</b> 41:23 91:20 98:12 102:11 <b>commencing</b> 2:9 113:13 <b>comment</b> 41:3 50:9 56:11
--	---	--	--	--

109:21 <b>commentary</b> 109:2 <b>commenting</b> 23:25 <b>commission</b> 113:24 <b>commitment</b> 18:2 <b>common</b> 30:9 46:7 47:19 56:18 57:17 58:8 88:12 <b>communicating</b> 29:11 <b>communicatio...</b> 102:4,11,16 <b>companies</b> 18:5 <b>compare</b> 42:5 <b>compensation</b> 18:25 102:6 <b>complain</b> 46:19 47:1 <b>complaint</b> 47:14 <b>complaints</b> 98:20 <b>complete</b> 101:18 <b>completely</b> 35:1 <b>complex</b> 43:17 <b>complications</b> 77:19 <b>conceivable</b> 35:22 <b>concern</b> 16:15 <b>concerning</b> 52:5 <b>concierge</b> 18:12 <b>concluded</b> 112:8 <b>concluding</b> 2:9 <b>conclusion</b> 34:12 <b>condition</b> 38:23 75:5 79:25 80:8 87:22 <b>conditions</b> 58:4 58:5,6 74:4 76:16 82:15 <b>conference</b> 27:11	<b>confirm</b> 9:24 107:17 <b>confused</b> 14:13 49:13 <b>congestion</b> 63:22 <b>congestive</b> 14:2 14:4 50:21 62:16 66:25 71:10 74:6,13 92:4,5,12,13 92:15,16,22,25 93:3 <b>conjunction</b> 89:7 <b>connected</b> 30:23 <b>connection</b> 103:2 <b>consequence</b> 55:11 86:24 <b>consequences</b> 36:24 <b>consider</b> 32:12 76:23 77:15 80:1,9 <b>considered</b> 32:21 39:19 75:5,25 76:17 76:21 77:4 78:1 79:13,16 81:20 <b>considering</b> 77:16 <b>consistent</b> 7:21 44:22 92:10 99:12 <b>conspiring</b> 85:8 <b>Constitutional</b> 22:16 <b>consult</b> 27:17 28:14,21,22 29:1,9,19,22 30:6 72:18 73:8,20 78:19 78:25 <b>contact</b> 18:17 <b>context</b> 26:17 30:22 42:6	69:10 <b>contextual</b> 41:21 <b>continue</b> 16:3 35:23 44:25 <b>continued</b> 3:1 95:17 <b>contract</b> 23:13 <b>contribute</b> 90:13 <b>contributed</b> 64:25 <b>contributing</b> 66:21 67:3 82:22 96:8 98:6 <b>contribution</b> 66:24 68:12 <b>contributor</b> 68:18 <b>control</b> 67:10 <b>controlled</b> 95:11 95:11 <b>conversation</b> 82:17 <b>copies</b> 4:18 112:12 <b>coronary</b> 27:5 31:6 45:23 46:7 47:6,23 47:24 48:3 62:17,21 64:18 64:19,23,24 65:1,7,8,11,17 75:23,23 76:6 76:8 88:13 93:4,9,10,14 93:15,17 98:21 98:25 111:6 <b>corporate</b> 107:24 108:5,6 108:13 <b>corporations</b> 108:10 <b>correct</b> 6:15 9:21 11:18 13:8 15:4 16:1 17:6 19:2 21:20 23:11,12 23:14,15,17,18	23:23 24:10 25:22 27:22 28:13 43:1 53:24 54:7,7 59:5 61:7,9 62:8 66:7,8,21 68:15 71:2 85:3 87:19 88:9 89:2,9 90:24 92:2 93:1 94:2 100:25 102:2 103:16,25 104:4,5 106:7 106:20 108:3,8 114:11 <b>correctional</b> 1:7 23:11,14,22 24:8 25:6,7 34:18 41:7 84:22 100:17 108:7 <b>corrections</b> 114:11 <b>correctly</b> 57:19 <b>corresponds</b> 73:10 <b>cough</b> 40:6 <b>counsel</b> 84:21 103:14 113:15 113:17 <b>count</b> 6:22,25 <b>counted</b> 11:16 <b>county</b> 3:11 23:22 24:8 84:21 113:2 114:3 <b>couple</b> 25:14,19 27:8 28:15,18 28:24 41:6 <b>course</b> 8:3 42:15 54:1 64:8 66:8 66:9,10,23 76:8 87:21 101:7 105:20 <b>court</b> 1:1 7:11 12:24 13:8 14:25 15:8	22:6 <b>cousin</b> 70:21 <b>cover</b> 28:10 <b>coverage</b> 28:5 28:24 <b>covering</b> 29:3,4 <b>covers</b> 18:25 <b>COVID</b> 11:14 11:19 15:13 <b>created</b> 41:7 <b>creates</b> 80:25 <b>credential</b> 26:4 <b>criticism</b> 99:23 <b>criticisms</b> 108:9 <b>cued</b> 54:9 <b>current</b> 16:6 24:14 25:19 95:18 <b>currently</b> 25:21 <b>curriculum</b> 4:11 6:7 10:13 25:12 <b>curve</b> 42:5 74:2 74:5 78:5,12 <b>cut</b> 41:6 67:24 <b>cutoff</b> 59:16,21 <b>cuts</b> 104:13 <b>CV</b> 32:10 106:19
<b>D</b>				
<b>D</b> 4:1 <b>D-O-C</b> 32:6 <b>D-O-C-K</b> 32:6 <b>daily</b> 73:5 <b>damage</b> 50:18 69:7 74:9 86:23 89:21 100:8 <b>damaged</b> 58:11 59:9 86:20 92:23 <b>damages</b> 20:8 <b>Danielle</b> 3:11 <b>dark</b> 38:1,4,11 39:2,3,4 <b>darkness</b> 39:9 <b>data</b> 32:21 51:8 51:24 52:17				

63:15 78:15,19 79:1 102:13 <b>dated</b> 5:23 102:23 114:16 <b>day</b> 2:8 27:10 34:23 35:6 36:3 52:24 53:7,14 54:5 59:25 61:5 65:23,25 67:11 68:24 78:18 104:15,17,22 110:15 113:12 113:21 114:17 <b>day-to-day</b> 31:20 72:19 73:24 74:1,16 <b>daytime</b> 104:13 <b>de</b> 55:21 <b>dead</b> 48:9 58:11 85:24 <b>deal</b> 73:14 77:10 <b>dealing</b> 80:15 <b>death</b> 64:25 81:1 <b>debate</b> 109:2 <b>December</b> 33:7 45:11,19 52:19 54:18 59:1 65:20 83:12 85:3 <b>decisions</b> 48:4 <b>defend</b> 20:2,6 <b>defendant</b> 12:20 20:23 21:14 <b>defendants</b> 1:8 1:15 2:3,20 3:5 3:10 11:23 107:9 <b>defending</b> 21:1,3 <b>defense</b> 6:2 8:4,5 19:11,13,18 20:1,4,6,10,12 20:16 21:5 100:9 101:20 103:11 105:20 105:23 111:20 <b>defibrillator</b> 81:8,10	<b>define</b> 67:18 <b>defined</b> 69:6,7 <b>definitely</b> 61:19 <b>definition</b> 93:4 <b>degree</b> 44:11 45:7,17 51:10 63:12,13 77:23 83:9,14 86:9 98:6 100:13 <b>delay</b> 51:15 <b>delivered</b> 65:5 <b>delivery</b> 88:10 <b>delving</b> 77:21 <b>demand</b> 46:4 65:3,11,13 88:16,17,24 89:3,13 90:9 93:8 <b>demand</b> 88:11 <b>dependent</b> 77:3 <b>depends</b> 42:6 69:10 78:17 <b>depo</b> 15:19 <b>deposed</b> 6:20 49:13 <b>deposition</b> 1:17 2:1 4:13 7:13 9:2,14 10:16 11:8,10,15 21:10 22:4 25:2 103:12,24 104:3,12 105:6 105:13 106:1 107:23 111:20 112:8,9 113:6 113:11 <b>depositions</b> 5:16 6:13,16 7:6,15 7:18,19 112:2 <b>depressed</b> 43:19 67:4 <b>depression</b> 43:21,25 45:2 55:4,7 <b>deprivation</b> 33:25 <b>describe</b> 33:18 43:12	<b>described</b> 44:24 74:3 94:15 <b>descriptor</b> 91:21 91:22 <b>despite</b> 70:15 75:22 95:18 <b>detail</b> 12:11 <b>details</b> 13:24 36:22 48:6 <b>detainee</b> 22:1 <b>detainees</b> 24:9 <b>determine</b> 48:25 66:16 <b>determining</b> 22:20 <b>developed</b> 16:14 85:5,13 <b>developing</b> 61:15 <b>diagnose</b> 48:7 81:11 <b>diagnosed</b> 92:11 <b>diagnoses</b> 38:16 <b>diagnosis</b> 44:16 <b>diagnostic</b> 57:10 58:18 <b>dialysis</b> 71:24 <b>diastolics</b> 69:9 <b>didactics</b> 30:21 <b>die</b> 51:17,17 85:22 86:10,16 86:16,17,18 <b>died</b> 49:11 64:12 <b>difference</b> 23:6 39:11 48:6 49:6,18 74:25 82:18,19 <b>different</b> 27:20 29:5 43:9 53:15 58:7 72:8 74:10 79:6 80:21 97:7,8 104:24 110:13 <b>difficult</b> 39:16 90:22 <b>difficulty</b> 39:11 39:15 88:20	<b>dig</b> 21:7,16 77:15 <b>digest</b> 32:18 <b>dilated</b> 98:13 <b>direction</b> 113:9 <b>directly</b> 113:18 <b>director</b> 31:7 <b>disagree</b> 37:14 96:15 97:2,22 <b>disagreed</b> 49:12 94:9 100:10 <b>disagreeing</b> 109:24 <b>disagreement</b> 96:19 <b>discipline</b> 106:13,15 <b>disclosed</b> 6:4 <b>discloses</b> 6:7 <b>disclosure</b> 10:20 <b>discomfort</b> 34:4 34:8 51:5 <b>discuss</b> 27:14 <b>discussed</b> 37:22 38:25 55:4 <b>discussion</b> 103:13,18 <b>discussions</b> 30:18 <b>disease</b> 45:23 63:21,24 64:19 65:17 72:15,23 73:13 76:6,8 90:17,18 98:21 98:25 99:2 110:7 <b>dismissed</b> 47:6 <b>disorder</b> 69:22 69:25 70:3 <b>dissertations</b> 105:22 <b>distinction</b> 53:23 <b>distress</b> 34:4,7 34:13 <b>distressed</b> 34:16 <b>DISTRICT</b> 1:1 1:2	<b>diuretic</b> 69:25 92:17,18 <b>diuretics</b> 74:11 <b>dknott@lkgl...</b> 2:19 <b>Doc</b> 54:9 <b>Doc2Dock</b> 31:18 <b>Doc2Dock.com</b> 32:3 <b>doctor</b> 5:10 6:17 8:13 16:3,11 19:5,14 20:3,6 20:18 21:1,25 24:2,14,23 26:3,16 32:16 36:17 39:11 40:6 41:3,11 42:13 43:4,15 45:6 46:11 48:17,17,22 49:19 50:5 53:20 54:12,24 55:17 56:2,15 61:24 64:5,14 64:21 65:18 69:6 71:4 72:18 73:25 74:18 75:12 78:7,15 81:25 83:9,21 84:10 84:17 96:9,9 97:18 106:24 107:3 108:22 110:2 111:17 <b>doctor's</b> 42:3 <b>doctors</b> 17:9,22 26:11 27:4,19 28:22 29:2 107:11 <b>document</b> 24:24 41:7 <b>documentation</b> 36:15 <b>documented</b> 53:18 <b>documenting</b> 35:25 <b>documents</b> 9:13
--	--	---	--	--

10:5	24:15,17	<b>emergency</b> 30:7	<b>evaluate</b> 64:2	76:18 77:5,11
<b>doing</b> 35:19 38:3	<b>easiest</b> 12:22	30:8 31:8	<b>evaluated</b> 35:22	77:13,17 78:5
40:25	<b>easily</b> 20:5 81:3	42:14 54:17,24	<b>evaluation</b> 47:22	78:12,16,23
<b>dose</b> 70:24	<b>east</b> 3:3 15:21,22	63:8	<b>evening</b> 35:13	79:2,13,17,22
<b>doses</b> 60:16 95:8	<b>echocardiogra...</b>	<b>emotions</b> 41:24	62:14 110:15	80:2 81:21
<b>Dot</b> 32:3,7,8	16:17,18	<b>employed</b> 17:15	<b>event</b> 44:23	82:2,10
<b>Douglas</b> 2:17	<b>ED</b> 4:15	<b>employee</b>	49:24 50:7	<b>expenses</b> 104:16
<b>downs</b> 50:10	<b>edema</b> 61:12,14	113:15,16	86:25 87:17,18	<b>expensive</b> 31:22
<b>Dr</b> 5:14 8:10,11	61:15,17 92:21	<b>employees</b> 16:25	<b>events</b> 33:17	<b>experience</b>
8:13,18,21,25	<b>edition</b> 93:25	<b>end-organ</b> 38:7	82:23 87:3,18	110:3,15
9:22 24:3	<b>EF</b> 88:20	69:7	<b>evidence</b> 36:2,5	<b>experienced</b>
33:23 49:6	<b>effect</b> 19:22	<b>ended</b> 111:9	36:12,14 92:19	37:11 53:21
93:20 94:3,8	<b>eight</b> 15:20 95:8	<b>endocrine</b> 80:11	92:22,25 95:5	110:22
96:14 97:3,21	97:6,9,21	<b>ends</b> 54:22	95:12	<b>experiencing</b>
100:11 108:1	<b>either</b> 64:10	<b>endurance</b>	<b>exact</b> 7:2	34:4 44:12
109:8,11	67:1 86:14	39:25	<b>exactly</b> 13:3	45:9,9,18 53:7
<b>draw</b> 34:11	89:7 99:3	<b>engaged</b> 30:20	52:11	54:4 66:6
<b>drop</b> 59:19	100:6	<b>engaging</b> 48:15	<b>exam</b> 26:25	82:24 83:11,15
60:18	<b>ejection</b> 91:12	<b>entitled</b> 48:23	<b>EXAMINATI...</b>	110:6,11
<b>drops</b> 86:14	91:14,15,16	<b>entity</b> 17:16	4:2	<b>expert</b> 8:6 49:9
<b>Drs</b> 107:11	92:14	25:25 27:22,24	<b>examine</b> 77:22	53:21 100:9
<b>drug</b> 56:24	<b>EKG</b> 42:16,18	<b>epinephrine</b>	<b>examined</b> 5:3	104:11 105:18
70:14,17,20	42:20,21,23,24	60:16,17,22	<b>example</b> 12:7	<b>experts</b> 105:7,14
77:8 95:12,13	43:16 44:9,18	<b>episode</b> 34:22,24	32:21 56:23	<b>expires</b> 113:24
<b>drugs</b> 67:10 77:8	44:21,24 45:5	35:7,8 58:25	86:11	<b>explain</b> 33:3
82:22,24 83:1	46:15 54:21	62:3 88:19	<b>exams</b> 16:19	43:15 70:1
83:11 90:13	55:1,18 62:23	<b>episodes</b> 50:25	<b>exceed</b> 24:15	<b>explanation</b>
95:7,15,20	62:25 89:1	51:6 62:13	<b>exclude</b> 36:1	85:9,18 86:6
<b>drunk</b> 39:2,3	110:10	88:25	67:12	87:9
<b>duces</b> 9:13 10:20	<b>EKGs</b> 44:5 55:3	<b>episodic</b> 35:2,5	<b>exhausted</b>	<b>explicitly</b> 107:19
<b>due</b> 52:18 65:11	<b>electrical</b> 87:17	36:3 48:5	108:17	<b>explore</b> 33:5
98:1,9,19,24	87:18	52:23 65:25	<b>Exhibit</b> 4:10,11	<b>extensively</b>
99:6 110:3	<b>electrolyte</b> 56:13	68:18,23	4:12,13,14,15	106:3
<b>duly</b> 5:3	56:16 57:10,12	<b>equivalent</b> 39:20	4:16 10:14	<b>extent</b> 52:7
<b>duress</b> 34:9	57:13,22 58:14	<b>ER</b> 27:5 30:4,6	11:8 14:19	
<b>dynamic</b> 65:9	59:4 68:13	47:21 52:13	21:11 25:13	<b>F</b>
	<b>electrolytes</b>	78:10 81:5	54:11 55:16	<b>F</b> 44:2
	56:21,22 57:18	<b>ERs</b> 78:9	102:22 112:9	<b>facility</b> 23:11,14
	58:6 60:7	<b>especially</b> 58:10	<b>exhibits</b> 4:18,18	<b>fact</b> 48:23 58:20
	<b>electronically</b>	<b>essentially</b>	112:11,12	66:2 81:19
	112:10	103:22	<b>expand</b> 17:8	98:10
	<b>element</b> 56:14	<b>established</b>	<b>expect</b> 29:12	<b>factor</b> 66:21
	<b>elevated</b> 41:16	50:19	44:25 45:4	67:3 74:5,7
	41:19,20,20	<b>Estate</b> 1:4,11	<b>expectancy</b> 39:6	75:25 76:5
	42:12 43:19	<b>estimate</b> 6:23,24	71:1,13 72:5,6	77:4,25 79:12
	46:18,24 87:10	6:25 82:12	72:24 73:12,17	81:20 82:17
	87:20 89:4,6	<b>et</b> 1:7,14	73:23 75:9,16	96:8 98:7
	<b>elevation</b> 55:6	<b>etiology</b> 47:15	75:20 76:1,5	<b>factored</b> 103:21

<b>factors</b> 75:23	105:24	108:21	20:20 22:5,8	32:19 42:20
<b>facts</b> 85:10,18	<b>final</b> 6:1 9:20	<b>following</b> 99:17	98:13 107:11	52:1 64:14
102:13	99:15 102:24	<b>follows</b> 5:4	<b>fraction</b> 91:12	71:13 103:19
<b>Factual</b> 36:18	103:21	<b>footage</b> 33:7	91:14,15 92:14	<b>gives</b> 33:22
<b>failing</b> 95:14	<b>finally</b> 27:15	34:2	<b>fractions</b> 91:16	97:25
<b>failure</b> 14:2,5,8	<b>finance</b> 108:13	<b>foregoing</b> 114:8	<b>frankly</b> 49:5	<b>giving</b> 30:25
38:8 62:17	<b>financial</b> 108:6	<b>forever</b> 70:22	<b>French</b> 55:24	36:8 40:20,23
66:25 69:12	<b>financially</b>	<b>forgot</b> 91:13	<b>frequently</b> 43:21	52:3 99:19,24
71:10 72:1,9	113:17	<b>form</b> 13:9 16:14	<b>Friday</b> 93:19,22	100:5
72:14,16 74:6	<b>find</b> 5:18 17:9	18:6 19:16	93:24	<b>gloss</b> 32:20
74:7,9,14,22	20:5 24:23	22:25 23:24	<b>front</b> 8:18,22	<b>go</b> 5:20 6:6 15:8
89:24 91:25	26:8 31:11	24:11 29:16	<b>fuel</b> 65:4 88:17	19:3 26:18,22
92:4,6,12,13	47:24 59:18	34:5,14 35:14	93:8	26:23 27:18
92:15,16,23,25	81:6,11 93:2	38:24 41:15	<b>full</b> 5:7 62:4,6	35:1,3 36:22
93:3	<b>findings</b> 44:21	45:12,20 46:21	<b>function</b> 74:16	48:17 60:1,2
<b>fair</b> 21:24 22:24	64:17	47:16 50:1	87:12 89:3	69:9 84:6
23:19 24:6	<b>fine</b> 48:25 49:20	52:21 53:25	<b>further</b> 25:17	89:23 94:11
26:15 28:6	111:10	56:9,12,17	59:9 108:20	96:10 97:15,15
29:15 46:20	<b>Finish</b> 109:12	57:7 58:1,2,8	113:10,14	97:23 109:12
47:13 52:16	<b>firing</b> 67:16	59:15 60:13		<b>goes</b> 88:18 90:10
53:8 56:8 73:9	<b>firm</b> 11:25 13:6	66:15 70:9	<b>G</b>	<b>going</b> 8:16 10:13
75:6 76:1	13:15,16,22	71:11 75:7	<b>GAYNOR</b> 2:17	18:11 19:24
78:20 93:25	102:1,6,12,17	76:2 78:2,21	<b>general</b> 29:7	20:9 25:18
105:21 108:4	105:1	79:4,14,20	52:13 91:21,22	37:21 40:8
<b>fairly</b> 49:1	<b>firm's</b> 12:12	80:3 82:4	<b>generally</b> 29:13	49:2 51:25
<b>familiar</b> 12:13	<b>firms</b> 19:18	83:17 86:4	<b>generically</b> 14:4	52:4,11 57:3
<b>far</b> 40:16 99:4	<b>first</b> 5:2 7:3 8:10	87:25 89:5	<b>GERAGHTY</b>	58:3,15,16
<b>fatal</b> 98:3,9,10	20:25 21:6	96:16 97:5	3:2	63:15,18 68:22
<b>favorable</b> 92:1	26:18 34:21	101:2,6 110:12	<b>getting</b> 29:10	71:19 72:1
<b>February</b> 5:23	36:18 37:17	<b>formal</b> 72:25	36:8 48:7	73:6 78:11
7:24 113:21	43:12 45:14	<b>formalized</b>	50:25 51:2	81:7,11 83:21
<b>fecal</b> 79:11	65:19,22,23	26:12	60:10 69:20	83:23 90:6
<b>federal</b> 2:4	66:4 105:11	<b>formally</b> 50:14	71:25 77:9	100:23 105:21
12:24 13:10	107:22 110:10	<b>forming</b> 101:11	78:9 88:21	107:3,3,20
<b>fee</b> 18:11,21	<b>five</b> 13:2 60:5,10	101:19 102:14	<b>GHS</b> 4:15,16	110:8
<b>feel</b> 22:15 39:18	72:2 82:9 84:5	102:19	<b>GHS1339</b> 54:12	<b>good</b> 11:6 71:18
89:23	107:4	<b>formulation</b>	<b>GHS1559</b> 55:15	75:24 104:23
<b>feeling</b> 111:6	<b>five-</b> 84:2	63:5,10,20	<b>giant</b> 25:24	106:18,18
<b>fellow</b> 29:3	<b>Fives</b> 40:1	<b>forward</b> 73:7	<b>give</b> 17:10 26:10	<b>gosh</b> 47:3
<b>fellows</b> 26:22	<b>flat</b> 18:21	111:20	27:3,6 31:5,10	<b>Great</b> 107:7
27:4	<b>Floor</b> 2:14	<b>found</b> 55:3	52:17 67:13	<b>greater</b> 59:20,20
<b>Fennigkoh</b> 2:20	<b>flow</b> 88:8 90:4	74:14 80:14	68:25 72:24	65:4
25:6	93:16	<b>Foundation</b> 34:6	73:12 94:22	<b>GREGORY</b> 1:3
<b>field</b> 101:10,11	<b>fluid</b> 92:20	47:17 52:22	107:15	1:10
<b>fight</b> 47:5	<b>focal</b> 62:24	70:10 76:3	<b>given</b> 5:16,23	<b>group</b> 71:17
<b>figure</b> 12:22	<b>focus</b> 64:4 81:6	78:3,22 79:15	6:13,17 7:5	<b>groups</b> 71:17
67:7	<b>focused</b> 62:10	80:4 82:5	12:10,15 26:4	<b>guarantee</b> 26:9
<b>file</b> 10:6 104:2	<b>follow</b> 84:18	<b>four</b> 10:23 15:2	29:18 30:16	<b>guess</b> 13:19

25:14 45:6 49:22 <b>gun</b> 38:2 <b>Gundersen</b> 4:15 37:19 42:25 43:2 68:11,17 105:16,17,23	32:17 33:1,4 43:23 44:1 45:25 56:20 59:9 60:4 62:16 63:21,24 65:4,12 66:25 69:12 71:10 72:9,13,16 74:6,7,9,14,22 87:24 88:8 89:11,21,23,24 90:17 91:19,25 92:4,5,12,13 92:15,16,22,25 93:3 99:2 110:7,16	<b>home</b> 5:14 6:8 6:11 <b>hone</b> 49:19 <b>hope</b> 71:24 <b>horrible</b> 71:23 78:8 <b>hospital</b> 16:20 16:24 17:21,23 26:4,19 29:8 31:9 40:23 42:23 46:13 47:25 48:9 49:10 51:11,21 64:10 74:12 83:4 85:23 86:25 90:18 98:10 100:6	<b>I</b> <b>ICUs</b> 78:10 <b>idea</b> 19:14,17 <b>identical</b> 43:10 <b>identifiable</b> 45:22 <b>identification</b> 112:10 <b>identified</b> 69:23 102:13 105:8 <b>identifies</b> 68:18 <b>identify</b> 33:13 68:12 <b>identifying</b> 68:14 102:18 <b>idiopathic</b> 91:5 <b>II</b> 44:2 55:4 <b>III</b> 44:2 55:5 <b>illegal</b> 77:8 <b>Illinois</b> 2:14 13:18 15:3 <b>imbalance</b> 56:16 57:22 59:4 68:13 <b>immediately</b> 51:13,23 <b>impact</b> 50:17 72:23 75:19 77:11 78:16 79:1,6,7,21,22 <b>impacted</b> 76:18 79:17 <b>impacting</b> 77:4 <b>implanting</b> 81:8 <b>important</b> 10:7 10:11 53:23 55:7 69:4 87:2 <b>incarcerated</b> 41:24 <b>include</b> 10:5 11:12 31:16 58:5,6 101:20 <b>included</b> 88:19 <b>includes</b> 12:18 32:10 72:7 106:19 <b>including</b> 79:6	100:11 <b>income</b> 24:21 <b>inconsistent</b> 68:1 <b>incontinence</b> 79:12 <b>increase</b> 46:4 65:11,13 88:24 95:20 <b>increased</b> 89:3 98:14 <b>independent</b> 78:25 <b>independently</b> 61:15 76:23 78:1 79:13 <b>indicative</b> 42:14 <b>indicator</b> 43:22 58:21 <b>indicators</b> 34:9 <b>indirectly</b> 113:18 <b>individual</b> 13:14 64:4 <b>individually</b> 76:20 80:1,9 <b>individuals</b> 71:10 <b>infarction</b> 98:19 <b>inferior</b> 43:25 55:5,8 88:2 <b>influenced</b> 57:8 <b>information</b> 12:10,16 17:11 33:22 50:23 <b>infrastructure</b> 31:23 <b>infringed</b> 22:13 <b>initial</b> 54:21 99:16 <b>initiated</b> 58:24 <b>injections</b> 60:17 <b>injuries</b> 36:25 <b>injury</b> 44:13 98:9 <b>inmates</b> 24:4 <b>input</b> 54:10 <b>instability</b> 59:20
<b>H</b> <b>H</b> 4:9 <b>hairpin</b> 67:17 <b>half</b> 16:9,14 18:10,10,13,15 18:15,23 20:13 45:14 78:18 94:24 <b>hall</b> 30:13 <b>hand</b> 48:2 59:24 68:20 91:24 113:20 <b>handful</b> 24:18 103:20 <b>hang</b> 96:25 <b>HANSEN</b> 3:7 <b>happen</b> 30:9 47:4 63:19 67:8 <b>happened</b> 11:4 51:8 53:17 63:9,14,21 67:9 <b>hard</b> 39:18 53:5 <b>Harmston</b> 3:6 107:11 <b>health</b> 18:3,5 32:19 <b>healthcare</b> 1:7 22:17 23:13,23 25:6,7 108:7 <b>healthiest</b> 71:17 <b>hear</b> 14:16 37:3 37:6 73:25 75:13 84:22 101:14 105:11 106:22 107:7 <b>heard</b> 26:6 <b>heart</b> 4:16 14:2 14:4,7 32:15	<b>heart's</b> 50:15 <b>held</b> 23:13 <b>Hendrickson</b> 3:11 <b>hereunto</b> 113:19 <b>Hi</b> 107:3 <b>high</b> 50:16 52:2 63:2,16 65:12 69:11 85:6,14 89:22 90:2,10 90:18 95:10 <b>higher</b> 50:20 <b>highlighted</b> 32:5 54:20 <b>highlighting</b> 8:24 10:7 <b>highly</b> 37:25 44:8,9 86:13 <b>Hill</b> 16:20 17:3,5 17:15,18 25:24 26:11 28:1,3,6 28:12,25 29:15 30:25 31:17 <b>history</b> 19:3 35:9 36:21 69:1 80:16 92:24 95:1 96:11 <b>Hofstra</b> 26:2,10 28:2,3 31:15 31:17 <b>hold</b> 53:6 82:23	<b>hours</b> 16:21 60:3 85:2 103:1 111:19 <b>house</b> 18:18 <b>hypertension</b> 32:23 63:22 67:18 68:18 69:6,8,13,15 69:17,18 70:8 76:20 88:20 94:17,18 95:2 95:6,7,18,23 96:13 99:2,6,8 99:9 <b>hypertensive</b> 42:14 49:24 50:7,24 51:6 62:2,13 70:13 88:19 <b>hypokalemia</b> 66:20,24 98:5 <b>hypoxic</b> 53:11		



<b>instance</b> 2:3	12:14 14:2	<b>J</b>	26:7 36:7 40:9	46:9,14,17
<b>instructed</b> 22:15	22:12 25:15	<b>jail</b> 22:2 24:8	49:15 52:12	48:2,22 50:22
<b>instructions</b>	48:19	41:8 51:15	91:10 95:3	51:2,4,7,9,23
26:23	<b>involves</b> 26:20	61:5 68:22	112:1	51:25 52:4,23
<b>insufficient</b>	<b>involving</b> 8:2	98:12 99:16	<b>Kiss</b> 13:19	53:1,4,5,10,12
88:10	11:22 22:1	106:2,4	<b>knew</b> 69:3,5	53:17 59:6,7
<b>insurance</b> 17:11	<b>Iowan</b> 56:1	<b>Jaime</b> 108:1	103:18	61:4 64:19
18:5	<b>irrelevant</b> 85:20	<b>January</b> 1:18	<b>Knott</b> 2:17,17	66:12,16,18
<b>insurers</b> 18:3	<b>irritable</b> 59:10	2:8 11:15	4:3 5:6 13:11	67:1 68:21,23
<b>intending</b>	<b>ischemia</b> 43:22	102:23 103:3,9	18:8 20:17	69:1,3,5,24
107:15	44:10,15,17,22	113:12,24	21:23 23:4	70:1,6,18
<b>intention</b> 23:2	45:1,3 46:16	114:9	24:1,13 25:1	71:18 72:23
<b>interest</b> 26:25	52:18 55:9,10	<b>jcasserly@go...</b>	30:2 34:17	73:6,11 79:5
31:10	56:9,10,11,14	3:4	36:10 38:14,20	80:10 82:6
<b>interested</b>	56:20 57:21,24	<b>jeopardize</b> 75:8	39:10,24 40:5	83:2,13,18
113:17	57:25 58:10,15	<b>jeopardizing</b>	41:17 45:15	85:1,4,18
<b>interfering</b>	62:17,22,24,25	75:16	46:10,23 48:10	89:16 90:14,24
74:16	63:24 64:23	<b>Jessica</b> 108:1	50:2 53:2,19	91:5 93:23
<b>Intern</b> 3:13	65:2,3,3,7,11	<b>Jillian</b> 3:6	54:2,8 57:11	99:24 110:4,23
<b>internal</b> 5:13	65:16 87:14,23	<b>Job</b> 1:23	61:1,11,21,23	<b>knowledge</b> 73:7
<b>interns</b> 26:21	88:2,7,10,12	<b>John</b> 3:2 8:9	66:19 67:23	<b>knowledgeable</b>
<b>interpret</b> 54:23	88:15 89:24	107:8 109:16	68:10 70:19	22:16
<b>interpretation</b>	90:8 93:5,7,7,9	<b>Johnson</b> 3:6	72:17 75:17	<b>known</b> 72:14
43:6,8	93:12,14,14,15	107:12 108:1	76:14 77:1,14	90:16
<b>interpreted</b> 56:3	110:3,6,12,16	<b>joined</b> 25:24	78:6,24 79:10	
<b>interval</b> 56:25	110:17,20,22	<b>Jones</b> 3:8 4:4	79:18,24 80:7	<b>L</b>
57:9 58:4,9,12	111:7,11	84:2,6,10,12	80:23 81:13,18	<b>lab</b> 55:14
<b>intervals</b> 56:19	<b>ischemic</b> 43:13	84:16,17 87:8	81:24 82:8,20	<b>labels</b> 100:15
<b>intervention</b>	43:14 44:6,13	88:6 89:8	83:21 84:1,4	<b>lack</b> 40:19
40:16	44:23 45:9,9	96:24 97:11	84:20 102:21	<b>lady</b> 90:16
<b>intoxicated</b>	45:18,24,24	101:3,8 103:6	107:14 108:19	<b>language</b> 93:11
37:18,25	46:8,11 53:1,5	106:24	108:21,24	<b>Lasix</b> 92:19
<b>intrinsic</b> 51:16	57:6 58:15	<b>judged</b> 22:17	109:7,13 110:1	<b>late</b> 71:21
<b>introduce</b> 83:23	98:24 110:9	<b>June</b> 30:14,15	111:8,13	<b>lateral</b> 44:2
107:7	111:2	30:16	<b>know</b> 7:2,3 8:7	<b>lawyer</b> 13:13,14
<b>introduced</b> 25:4	<b>Island</b> 26:2		12:1,17,20	21:3
<b>intubated</b> 78:9	<b>issue</b> 16:15 24:4	<b>K</b>	13:20 14:6,6	<b>lawyers</b> 13:17
<b>inverted</b> 43:24	37:12,13 47:11	<b>keep</b> 10:9,23	14:11 18:2,24	15:17,25 20:1
44:3	69:19 72:10	24:24 25:17	19:6 21:3,6,15	20:6
<b>invoice</b> 102:22	77:13,24 79:16	30:20 59:17	21:17,19,22,25	<b>layer</b> 90:3
102:24 103:10	80:21 82:10	<b>KENNEY</b> 3:2	22:12 24:14	<b>layperson</b> 43:15
103:16,22	83:20,20 88:15	<b>kept</b> 6:25 95:14	26:13 28:7	88:7
111:19	92:6 93:3 94:8	<b>kidney</b> 70:3	29:9,21,23	<b>lead</b> 1:6 13:16
<b>invoices</b> 4:12	94:11	<b>kill</b> 51:14 86:10	30:13 34:7,25	46:4 50:20
10:15 101:25	<b>issues</b> 22:23 27:5	<b>kills</b> 86:13	35:8,24 39:2	55:6 88:20,25
102:21 103:1	29:13 37:1,2,4	<b>Kimberly</b> 8:12	40:8 41:23	89:24
104:1	37:5 77:20	<b>kind</b> 6:22 20:7	42:16,18 43:8	<b>leading</b> 90:8
<b>involved</b> 6:18			45:1,21,21	<b>leads</b> 44:1,2,3

55:4,5,8 88:3 <b>leaking</b> 32:25 <b>leaky</b> 32:25 <b>leaned</b> 48:14 <b>lecture</b> 27:7 30:10,12,16,23 49:2,4 <b>lectures</b> 26:10 27:3 30:13 31:1 <b>led</b> 51:13 63:17 63:22,25 87:4 87:5 <b>left</b> 38:22 44:10 46:6 51:5 74:10 86:23 87:13,22 89:22 <b>leg</b> 92:21 <b>legitimately</b> 20:3 <b>LEIB</b> 2:17 <b>Lenox</b> 16:19 17:3,5,15,18 25:23 26:11 28:1,3,6,11,25 29:15 30:25 31:17 <b>let's</b> 6:6 66:3,3 71:14 <b>letterhead</b> 13:16 <b>letting</b> 17:13 <b>level</b> 59:12 60:11 61:4 65:15 67:4 74:15 80:25 87:14 <b>levity</b> 106:16 <b>license</b> 106:13 <b>licensed</b> 106:7,9 <b>Lidocaine</b> 56:24 60:1 <b>life</b> 37:1,7,13,21 38:9 39:5,6 70:25 71:5,12 72:5,6,24 73:12,17,23 75:4,9,16,19 76:1,5,18 77:5 77:11,13,16,23	78:5,12,16,23 79:1,8,13,16 79:17,22 80:2 81:21 82:2,10 82:16 <b>life-threatening</b> 36:25 37:12 <b>limit</b> 37:21 72:14 <b>limited</b> 39:6 <b>line</b> 94:23 <b>Lisa</b> 2:20 <b>lisinopril</b> 70:21 70:21,22 <b>list</b> 4:13,14 10:16,18,21,23 10:24 11:8,9 12:18 13:7 14:1,20 18:3 20:18,19,25 21:10 101:16 101:18 114:11 <b>listed</b> 17:5 97:7 <b>listener</b> 89:17 <b>listening</b> 107:13 <b>lists</b> 10:19 <b>literature</b> 9:23 101:10 <b>litigations</b> 6:19 <b>little</b> 25:17 54:13 76:4 96:17 106:16 110:13 <b>live</b> 37:15 38:22 71:19 <b>LLC</b> 2:17 3:7 <b>local</b> 88:1 <b>localized</b> 44:7 <b>locate</b> 71:4 <b>Loevy</b> 2:13,13 11:25 12:12 13:6 102:1,6 102:12 105:1 <b>Loggins</b> 13:18 13:22,22,23 <b>logical</b> 64:1 <b>long</b> 9:4 12:25 12:25 13:1 26:2 33:10	34:23 35:6 36:3 52:24 53:10 58:12 70:6,14 <b>long-term</b> 74:20 76:17 <b>longer</b> 34:24 71:19 <b>look</b> 8:9,16,16 9:23 14:1 18:21 34:16,21 38:5 61:24 71:5 83:23 <b>looked</b> 37:19 67:24 106:2 <b>looking</b> 17:8 21:12 36:17 44:1 46:15 95:6 106:4 <b>looks</b> 13:17 15:2 <b>lot</b> 19:19 29:18 32:18 51:25 58:6 60:22 62:23 80:19 <b>Lots</b> 34:10 <b>loud</b> 54:14 <b>low</b> 57:2 58:5,16 58:21 67:2,15 70:16 74:15 85:7,16 86:17 87:13,15 88:5 88:20 92:14 96:7 98:5,11 <b>lower</b> 57:4 59:22 59:22 <b>lowered</b> 67:15 <b>LV</b> 91:24 <b>Lynch</b> 108:2  <hr/> <b>M</b> <hr/> <b>M</b> 5:5 84:15 107:1 108:23 <b>M.D</b> 1:17 2:2 5:2 113:7 114:7,21 <b>magnitude</b> 78:13 <b>main</b> 49:9 85:20 85:22 86:7	96:2 100:4 <b>maintain</b> 10:21 <b>maintaining</b> 31:21 <b>major</b> 37:1,2,4,4 67:18 71:25 72:15 74:7 76:5 81:23 86:14 90:17 96:19,21 105:22 <b>majority</b> 17:17 <b>Makar</b> 2:13 9:2 13:9 18:6 19:16 21:21 22:25 23:24 24:11 29:16 34:5 35:14 37:16 38:18,24 41:15 45:12,20 46:21 47:16 50:1 52:20 53:9,25 54:6 56:17 59:15 60:13 61:22 66:15 67:21 68:3 70:9 71:11 75:7 76:2,24 77:7 78:2,21 79:4 79:14,20 80:3 80:18 81:2,16 81:22 82:4,13 83:17 84:5,8 86:4 87:25 89:5 96:16 97:5 101:2,6 102:5,12,17 105:14 109:6 109:12,15 110:24 111:16 111:22,24 112:4 <b>makar@loevy...</b> 2:15 <b>making</b> 24:24 65:14 <b>malignant</b> 69:6	69:15,17,18 72:1 98:14 99:6,7,9 <b>manageable</b> 79:23 80:10 81:3 <b>managed</b> 36:4 <b>management</b> 31:6 99:24 <b>manner</b> 33:20 83:4 <b>Margolis</b> 21:3 <b>Margolis'</b> 21:6 <b>Maria</b> 2:13 111:21 <b>mark</b> 10:13,14 10:15 54:11 55:16 <b>marked</b> 11:7 25:12 102:22 112:10 <b>marriage</b> 106:15 <b>match</b> 17:11 <b>materials</b> 105:5 <b>matter</b> 5:19 6:1 9:17 12:2 15:3 22:1,23 32:12 63:7 64:9 85:21 86:7,21 102:7 103:2 105:1 107:9 <b>matters</b> 13:21 14:24 15:15,25 <b>Matthew</b> 8:13 8:14 93:21 <b>MD</b> 4:12,13,14 <b>mean</b> 21:15 28:7 32:3 34:9,13 34:14 36:22 44:14,20 45:1 47:3,4 48:24 49:3,23 56:13 57:22 77:22 85:14 88:7 95:19 96:20 98:16 106:3 <b>meaning</b> 41:21 91:5 93:7
--	--	--	--	---

<b>meaningful</b> 75:10,14,15	73:11	<b>moderate</b> 91:9	<b>name's</b> 107:8	<b>noninvasive</b> 16:16
<b>means</b> 32:25	<b>medicines</b> 39:23	91:24	<b>named</b> 21:3 26:2	<b>normal</b> 19:22
34:15 35:2	<b>memorized</b> 96:17	<b>moderately</b> 41:19 42:12	<b>names</b> 8:6 12:8	50:16 56:21
57:3 69:11	<b>memory</b> 12:7	<b>moment</b> 39:9	<b>narcotic</b> 77:3	57:1 64:1,12
72:14 88:10	13:25 14:10	44:10 104:2	<b>narcotics</b> 51:2	72:5 91:16
91:17 93:18	<b>mention</b> 35:23	<b>money</b> 19:25	83:7	<b>normally</b> 93:15
<b>meant</b> 86:10	<b>mentioned</b> 83:7	<b>monitor</b> 4:16	<b>narrative</b> 103:10 106:4	<b>Norman</b> 3:6
<b>measure</b> 41:19	<b>met</b> 9:2	<b>Monroe</b> 3:11	<b>necessarily</b> 41:1	<b>North</b> 2:14,18
<b>measured</b> 42:3	<b>methodology</b> 31:23 64:2	24:8 84:21	<b>necessary</b> 80:12	3:8
<b>mechanically</b> 39:15	74:20 75:3	<b>month</b> 12:9	<b>need</b> 13:24	<b>northeast</b> 15:21
<b>mechanisms</b> 89:25	<b>Meyer</b> 13:19	27:15,17 28:20	18:11,17 39:23	<b>Northwell</b> 25:24
<b>medical</b> 1:14 3:5	<b>MI</b> 99:3	29:19 95:14	40:6,7,8 47:25	27:21,24,25
5:10 17:23	<b>microvascular</b> 65:15	<b>morning</b> 54:18	69:2 107:4,17	28:4
25:25 26:2,9	<b>mild</b> 42:12 78:11	58:25 85:2	107:20 108:21	<b>Nos</b> 112:9
26:20 28:2	91:9,24	104:3	<b>needing</b> 67:9	<b>notable</b> 95:1
31:14,16 36:21	<b>mildly</b> 41:19	<b>move</b> 41:4 52:7	92:20	96:12
37:5 38:5,10	<b>military</b> 18:13	109:18	<b>network</b> 25:24	<b>Notary</b> 2:6
38:13,23 44:12	<b>milligrams</b> 70:22	<b>moving</b> 40:10	<b>neurologic</b> 98:9	113:5,24
45:8,17 47:20	<b>millimeter</b> 43:20	<b>multi-resistant</b> 95:23	<b>neutral</b> 56:14	<b>note</b> 10:9 34:21
51:18 63:12,13	<b>millisecond</b> 108:15	<b>multidrug</b> 94:18	<b>never</b> 7:19,19	54:17 75:22
71:18 72:3	<b>Milwaukee</b> 2:18	95:2,3,5,17	20:9 23:10,13	<b>noted</b> 24:2
74:4,21 75:5	2:18 3:9 113:2	96:13	26:6 51:11,21	114:11
76:16,17 82:15	114:3	<b>multiple</b> 7:7 8:4	66:10 69:18	<b>notes</b> 4:15 8:24
83:10,15 85:5	<b>mind</b> 12:4 39:8	37:9 60:15	74:17 86:14	9:17,18,19,20
85:10,12 92:24	<b>minimum</b> 26:4	77:19 82:11	95:14 99:8,8	83:24
94:25 95:1,18	<b>Minnesota</b> 3:3	<b>Murray</b> 8:13	<b>new</b> 1:20,20 2:7	<b>Nothing's</b> 25:19
96:11 99:11,12	<b>minus</b> 65:8	<b>muscle</b> 43:23	2:8 6:2 8:13	<b>Notice</b> 2:5
107:10,19,25	<b>minutes</b> 40:1	58:11 65:14	16:20 17:12	<b>noticed</b> 104:8
108:6 110:5,11	60:10 107:4	88:21,22 89:25	22:3,10 25:25	<b>November</b> 92:7
111:1	<b>Mischaracteri...</b> 52:21	90:3,4,5,6	26:1 27:7	<b>number</b> 4:10
<b>medical-legal</b> 24:15	<b>misconceptions</b> 33:5	91:18	31:22 95:13	6:23 7:2,16
<b>medical-legally</b> 24:17	<b>mismatch</b> 88:16	<b>myocardial</b> 98:19	106:7,10,13	14:5 18:16
<b>Medicare</b> 18:13	89:12	<b>myth</b> 32:21	113:11,12	22:3 32:6
18:20	<b>missed</b> 45:13	<b>myths</b> 32:15,17	114:9,10	89:25
<b>medication</b> 40:24 57:21	80:5 105:10	<hr/>	<b>news</b> 75:24	<b>numbered</b> 97:1
<b>medications</b> 51:1 56:21	<b>Misstates</b> 79:15	<b>N</b>	<b>night</b> 27:9,12	97:3,21
57:17 58:7,8	80:4	N 2:12 3:1 4:1	29:4 35:19	<b>numbers</b> 10:10
70:13	<b>mistake</b> 24:24	5:5,5 84:15,15	50:11 104:14	<b>nurse</b> 8:12 23:16
<b>medicine</b> 5:13	<b>misunderstan...</b> 33:3	107:1,1 108:23	<b>nine</b> 15:20	23:16 25:5,5
22:21 26:5,24	<b>mitigate</b> 20:8	108:23	<b>non-ischemic</b> 56:7	109:1
49:21 72:21		<b>name</b> 5:7 8:10	<b>non-sustained</b> 53:16 66:17	<hr/>
		8:14 12:12,12	<b>noncardiac</b> 47:15	<b>O</b>
		12:19 13:16	<b>noncompliance</b> 80:16	<b>O 5:5</b> 84:15
		17:14 21:6		107:1 108:23
		26:8 32:4		<b>O'LOUGHLIN</b> 3:2
				<b>oath</b> 5:3

<b>object</b> 109:15	64:24 81:9	100:18	31:21 32:4	100:15,17
<b>objection</b> 13:9	86:7,15	<b>one-year</b> 39:6	<b>Original</b> 4:18,18	101:17 114:12
18:6 19:16	<b>occurring</b> 35:6	<b>ones</b> 21:5	112:11,11	<b>pages</b> 40:9 105:8
21:21 22:25	<b>occurs</b> 33:4	<b>Online</b> 71:5	<b>out-of-hospital</b>	<b>paid</b> 17:22
23:24 24:11	57:15	<b>onset</b> 48:1	51:16	<b>pain</b> 27:5 31:7
29:16 34:5	<b>October</b> 15:8	<b>open</b> 17:12	<b>outlook</b> 73:6	34:10,10,14,20
35:14 37:16	<b>Oddly</b> 63:5	62:16 90:6	<b>outpatient</b> 61:3	34:23 35:4,18
38:18,24 41:2	<b>offend</b> 49:3	<b>operations</b>	69:24 72:10	35:20,25 36:1
41:15 45:12,20	<b>offer</b> 5:19	31:20	92:8	36:2,3,12,15
46:21 47:16	<b>offered</b> 87:10	<b>opinion</b> 6:5 24:7	<b>outside</b> 38:18	37:9 39:17
50:1 52:20	94:8 96:25	36:9 44:11	47:17 86:25	42:7 45:10,18
53:9,25 54:6	97:1	48:8,20 49:8	106:15 109:16	46:5,15,19
56:17 59:15	<b>offering</b> 40:17	49:10 52:8,13	109:19	47:1,7,10,15
60:13 66:15	40:18 85:19,25	52:17 53:6	<b>outward</b> 34:8	47:19 48:2,16
67:21 68:3	86:2 99:13	62:7 63:7,11	<b>overall</b> 64:7	52:2,18,24,25
70:9 71:11	100:1,23	64:5,7,8 69:4	<b>overgeneralized</b>	61:12,13,16,20
75:7 76:2,24	<b>office</b> 3:11 16:18	70:25 82:1,23	32:20	63:2,18 67:11
77:7 78:2,21	16:21,22 42:3	83:3,19 85:19	<b>overlap</b> 7:18	68:24 69:13
79:14,20 80:3	42:11 47:20	85:21,22 86:1	109:23,25	77:10,12,16,18
80:18 81:22	48:3 113:20	86:2,8 97:8,9	<b>overload</b> 92:21	85:14,15 88:25
82:4,13 83:17	<b>officer</b> 41:8	97:10,25 98:1	<b>overwhelming</b>	90:19 92:9
86:4 87:25	<b>officer's</b> 34:19	98:16,18 99:4	17:17	99:1 110:3,8
89:5 96:16	<b>officers</b> 107:24	99:5,10,11,14	<b>oxygen</b> 33:25	110:15,22,25
97:5 101:2,6	<b>Oh</b> 11:6 14:16	99:15,21,25,25	46:4 86:14,15	111:2,6,11,11
107:7 110:24	37:8 47:3	100:4,15	88:10	<b>paper</b> 10:3
<b>objections</b> 81:2	109:15	107:21 108:5		<b>paragraph</b>
81:16	<b>okay</b> 6:6 7:23	109:4,22 110:2	<b>P</b>	43:12 62:1,4,6
<b>objective</b> 41:18	8:18 11:6,16	<b>opinions</b> 5:19	<b>P</b> 2:12,12 3:1,1	64:22 94:25
<b>observation</b>	18:23 21:18	6:1,3 9:24 23:1	<b>P-O-I-N-T-E-S</b>	<b>paragraphs</b>
100:16,20,24	25:9,10,21	23:2,19,21	55:23	36:19
101:4	27:21 28:5,17	24:12 33:15	<b>P.A</b> 3:2	<b>paramedic</b> 55:2
<b>obstructed</b> 65:7	37:14 40:2,12	39:2 40:17,18	<b>p.m</b> 1:19 2:10	<b>Pardon</b> 5:15
<b>obstruction</b>	43:5 55:15,25	40:23 49:4,7	34:20 35:12	<b>paren</b> 62:16,18
81:14	57:19 61:25	94:7,12 96:2	36:13,16 52:19	<b>Parker</b> 3:12
<b>obstructions</b>	62:9 64:15	97:1,3,6,9,21	65:20 66:4	<b>part</b> 13:13 25:23
77:20	69:20 74:24	101:12,19	84:13,14 112:8	39:19 44:1,15
<b>obstructive</b>	75:3 83:25	102:14,19	<b>p.r.n</b> 50:25 52:3	61:13 73:24
45:22 65:16	84:4,8,11,23	107:14,16	69:2	74:1,8 76:12
<b>obviously</b> 37:8	85:25 103:22	108:12 109:5,9	<b>pacemaker</b> 60:4	76:25 105:11
37:25 71:9	104:10 106:24	109:10,21	<b>pack</b> 78:18	<b>particular</b> 64:22
77:18 89:14	108:9,19 110:2	<b>opposed</b> 93:12	<b>page</b> 4:2,10	67:24 73:8
101:20	110:19 111:10	<b>optimize</b> 73:15	33:18 36:17	110:21
<b>occasions</b> 72:20	111:13,13,15	<b>order</b> 9:24	41:8 42:24	<b>particularly</b>
<b>occur</b> 56:10,19	111:23 112:6	<b>orders</b> 59:5	43:13 61:24	10:7,10
56:20,22 58:2	<b>old</b> 25:16	<b>org</b> 32:3,7,8	62:5,6 67:19	<b>parties</b> 113:16
86:25	<b>older</b> 71:21	<b>organ</b> 71:25	67:25 68:1	<b>partner</b> 31:21
<b>occurred</b> 50:6	<b>once</b> 21:9 28:15	90:18	74:18 94:22,24	<b>passage</b> 54:21
54:25 63:5	28:18,24	<b>organization</b>	94:24 97:7	<b>passed</b> 109:17

<b>passive</b> 12:7	<b>percent</b> 13:6	<b>picking</b> 100:14	58:16,21 59:12	41:18,22,25
<b>paste</b> 67:25	14:17 16:9,12	<b>piece</b> 12:15	59:18 60:11,18	42:8 46:18,22
<b>pasted</b> 41:6	16:22,23 19:10	<b>pieces</b> 101:9	60:19 61:4	46:24 50:10,17
<b>pathognomonic</b>	19:11,12,13,17	<b>pillar</b> 64:8	67:2,4,15	63:3,15,18
56:16	20:4,10,11	<b>pillars</b> 64:5	69:22 70:6,12	65:13 67:10
<b>pathology</b> 33:4	24:18,20,20	<b>pills</b> 50:25	70:15,16 80:17	69:11 85:6,15
64:17	26:12 32:24	<b>pinpoint</b> 66:3	80:19,21,25	86:17 87:11,21
<b>patient</b> 19:20	44:8 55:10	<b>Pisney</b> 2:20 25:5	85:7,16 87:14	89:4,6,22 90:2
26:23 38:21	60:20 76:10,10	<b>place</b> 38:4,11	87:15 88:5	90:11,19 94:15
42:11 57:2	86:15 91:13,14	<b>plaintiff</b> 1:5,12	92:18 96:7	95:10
58:19 59:7	91:17,17	12:19,21,21	98:5,11	<b>pressures</b> 50:13
64:2 67:20,22	<b>percentage</b> 19:7	19:8,10,13	<b>potassium-wa...</b>	50:20 52:3
73:8,16 98:24	20:16	20:14	70:17 79:25	<b>presume</b> 100:10
<b>patients</b> 16:3,8	<b>perfectly</b> 95:11	<b>plaintiff's</b> 19:19	80:8	<b>pretty</b> 26:3
17:12,24 18:9	<b>performance</b>	<b>plaintiffs</b> 2:16	<b>potentially</b> 70:7	40:11
18:10,13,21,23	50:18	11:22	75:8,21	<b>prevented</b> 51:22
19:1 26:19	<b>performed</b>	<b>please</b> 5:7 14:14	<b>powerful</b> 12:6	<b>previous</b> 15:14
27:18 28:11,12	47:22	42:17 45:13	<b>practice</b> 16:9,21	<b>previously</b> 67:24
28:16,21 29:1	<b>period</b> 35:3	<b>plus</b> 65:8 104:15	16:25 17:9,18	104:18
30:4,5 56:18	62:18	<b>pneumonia</b>	18:12,15,16	<b>primary</b> 16:11
56:23 73:20	<b>periods</b> 60:6,8	86:12,13	24:16 31:5	16:13 17:22
<b>pattern</b> 56:7	95:9	<b>point</b> 39:8 50:12	38:21 72:19,21	47:14 96:3
57:20	<b>permanently</b>	50:25 51:4	73:5,24 74:1	98:1
<b>Paul</b> 3:3	86:20	58:13 60:5	<b>practiced</b> 23:10	<b>principle</b> 99:4
<b>pay</b> 18:9,10,21	<b>person</b> 41:23	68:9 83:6 87:1	<b>practices</b> 17:11	<b>printed</b> 11:1
18:24	52:1 57:5	94:21 96:22	<b>practitioner</b>	<b>prior</b> 34:2 35:10
<b>pays</b> 18:15	60:12 69:7,10	<b>pointes</b> 55:21,23	23:17 25:5	72:12 98:20
<b>PDF</b> 10:2,4	<b>personal</b> 113:8	56:4	<b>pre-deposition</b>	<b>prison</b> 22:2
<b>Pearson</b> 8:12,21	<b>personnel</b> 99:16	<b>points</b> 49:20	103:13	<b>private</b> 17:17
109:1,1,2	<b>pertinent</b> 33:13	<b>police</b> 38:1	<b>precipitated</b>	18:9,24 25:7
<b>pelvic</b> 36:23	33:14	<b>policies</b> 23:23	56:12 59:3	26:16 28:22
<b>pelvis</b> 37:10	<b>Pezze</b> 1:23 2:5	<b>poor</b> 93:6,10,13	96:6 98:4	29:2 31:4
77:21	113:4,23	<b>population</b>	<b>predated</b> 98:12	<b>privileges</b> 17:3
<b>pending</b> 15:15	<b>phenomenon</b>	71:13,14,22	<b>predictably</b> 38:9	<b>probability</b>
<b>penetrate</b> 90:5	35:5	73:18,23 74:2	<b>prep</b> 103:21	44:12 45:8,17
<b>people</b> 7:14 9:7	<b>phone</b> 18:16	<b>portion</b> 88:8	<b>preparation</b>	83:10,15
17:9,10 18:12	19:19	96:14	103:12	<b>probable</b> 53:22
18:14 31:13	<b>phrase</b> 29:17	<b>possibilities</b>	<b>prepare</b> 30:18	54:3
32:23 33:5	<b>phrased</b> 96:12	35:17	105:5,12,25	<b>probably</b> 6:20
34:10 39:2,13	<b>physical</b> 16:19	<b>possible</b> 47:12	<b>prepared</b> 5:24	9:6 13:5 15:20
39:14 40:25	26:25	53:15 61:16	<b>preparing</b> 9:22	21:7 22:4 65:1
46:18,22 47:6	<b>physician</b> 29:12	<b>post</b> 44:20	103:23	76:10
47:13,20 59:16	54:25	<b>post-arrest</b>	<b>prescribed</b> 77:9	<b>problem</b> 46:2
60:1 62:23	<b>physicians</b> 17:15	99:23	<b>present</b> 3:13	50:23 57:10,12
71:14,20,23	<b>physiologic</b>	<b>postulating</b>	47:13 55:10	70:6 74:21
72:7 73:12	80:22	64:24	68:22	76:18 79:23
80:19 91:17	<b>physiologically</b>	<b>potassium</b> 53:14	<b>presents</b> 57:20	80:20 81:3
92:13	50:5	57:2,3,5 58:5	<b>pressure</b> 41:16	<b>problems</b> 57:14

71:18 72:3,8 75:9,13,15 82:16 <b>Procedure</b> 2:4 <b>procedures</b> 23:23 37:9 <b>proceedings</b> 5:1 106:16 114:8 <b>process</b> 10:5 90:23 <b>professional</b> 6:9 6:11 16:6 24:16 <b>professor</b> 26:5 <b>profound</b> 59:16 65:12 <b>profoundly</b> 59:13 <b>prognoses</b> 71:24 <b>prognosis</b> 73:6 73:21,22 <b>progressively</b> 59:20 <b>prolong</b> 57:8 58:4,9 <b>prolonged</b> 48:5 56:19 57:1 <b>pronounce</b> 55:22,25 <b>pronouncing</b> 55:24 <b>proof</b> 44:9 <b>proposing</b> 50:6 <b>prospective</b> 73:14 <b>protocols</b> 60:17 <b>provide</b> 18:4 19:1 23:13 28:24 30:23 <b>provided</b> 10:16 10:18,24 14:21 23:20 24:7 30:10 40:13 42:16,18 99:11 101:16,23,25 102:21 105:8 105:15,19 <b>provider</b> 4:15	22:17 25:8 54:17 <b>providers</b> 18:3 55:20 68:14 <b>provoke</b> 55:11 <b>provoked</b> 62:2 62:12 <b>provoking</b> 62:16 <b>psychological</b> 1:14 3:5 38:12 38:15 107:10 <b>public</b> 2:6 17:14 113:5,24 <b>publications</b> 32:10,11 106:20 <b>publicly</b> 32:19 <b>published</b> 32:13 32:15 <b>pull</b> 26:19 <b>pulled</b> 67:16 <b>pulmonary</b> 61:12,14,15,17 <b>purported</b> 35:1 <b>pursuant</b> 2:3,4 <b>put</b> 20:18 21:9 24:4 25:11 55:15 60:4 91:22 <b>puts</b> 60:11 <b>putting</b> 10:6 14:19 38:3 95:13	43:4 45:6,16 47:18 50:3 52:15 66:2 73:19 82:6 92:2 97:17 104:24 107:22 109:18 110:13 110:20 <b>questioning</b> 5:22 109:16,17,19 <b>questions</b> 23:8 48:23 83:22 84:18 104:23 108:17,20 111:14,16 <b>quick</b> 39:21,23 <b>quickly</b> 40:11 <b>quite</b> 49:5 <b>quote</b> 68:11 74:2	53:4 60:21 64:8 69:25 74:13 86:8 87:2 92:15 111:3 <b>Realtime</b> 1:24 2:6 <b>reason</b> 51:18 55:13 57:14 58:22 61:14 91:6 <b>reasonable</b> 44:11 45:7,17 63:12,13 67:14 81:7 83:9,14 85:5,9,11,13 86:5 88:1 99:12 104:16 110:11 111:1,5 111:11 <b>reasons</b> 90:12 <b>rebut</b> 96:23 <b>recall</b> 42:21 43:9 43:11 69:16 70:17 99:22 100:20 102:23 <b>received</b> 40:24 40:24 56:24 99:16 <b>recess</b> 40:3 84:13 <b>recognize</b> 14:22 21:12 <b>recollection</b> 13:21 33:12 <b>record</b> 5:8 79:15 80:4 97:18 <b>recorded</b> 62:13 113:7 <b>records</b> 37:19 38:6 68:11 92:6 101:16,19 101:22 105:8 105:12,16,18 106:2 <b>recover</b> 45:3 <b>recovered</b> 59:8 86:19	<b>recovery</b> 45:5 <b>recurrent</b> 35:5,7 35:10,21 36:23 74:12 78:10 <b>reduce</b> 65:14 90:3 <b>reduced</b> 53:15 59:13 72:6 87:12 88:8 93:16 113:8 <b>reduction</b> 88:24 91:24 <b>refer</b> 93:15 <b>reference</b> 9:23 42:24 64:22 82:21 96:11 100:14 <b>referenced</b> 11:10 65:21 71:1 <b>referral</b> 17:13 <b>referring</b> 42:22 94:22 <b>reflection</b> 39:7 <b>refractory</b> 59:25 79:11 <b>regard</b> 8:1 <b>regimen</b> 95:19 <b>register</b> 29:24 <b>regularly</b> 26:10 <b>reject</b> 19:18 <b>relate</b> 39:13 92:14 <b>related</b> 70:7 87:6 <b>relating</b> 102:6 <b>relative</b> 66:23 67:20,22 113:15,16 <b>relevance</b> 48:25 <b>relevant</b> 32:12 32:14 36:21 <b>relied</b> 101:11 102:14,18 <b>relooked</b> 33:10 105:16 <b>rely</b> 28:22 <b>remember</b> 8:10
		<b>R</b> <b>R</b> 2:12 3:1 4:22 <b>radiating</b> 46:5 <b>raised</b> 69:18 <b>raises</b> 70:15 <b>raising</b> 99:22 <b>Rakhit</b> 20:25 <b>range</b> 91:16 <b>rare</b> 72:20 <b>rate</b> 40:6 41:5 104:10,18,20 <b>rates</b> 104:25 105:2,4 <b>reach</b> 7:16 <b>reached</b> 100:5 <b>reaching</b> 101:12 <b>read</b> 12:8 15:14 38:1 54:12,14 54:15,16 111:25 112:3,6 114:8 <b>reading</b> 100:9 <b>reads</b> 54:19 103:10 <b>real</b> 64:3 <b>really</b> 13:3 29:10 42:4 49:12 50:11 52:9		
	<b>Q</b> <b>QRS</b> 43:17,18 <b>QT</b> 56:19,25 57:9 58:4,9,12 <b>qualification</b> 60:14 <b>quality</b> 37:1,7 37:13 77:23 79:8,16 <b>quantifying</b> 91:20 <b>quantitative</b> 72:25 <b>question</b> 28:17			



12:2,8,11,16 13:3,24 14:16 15:6 21:8,16 42:20 44:18 59:6 76:9 93:22 96:18,21 <b>Remote</b> 2:1 <b>remotely</b> 1:20 2:7 5:3 113:7 113:11 114:9 <b>reoccur</b> 35:4 <b>reoccurs</b> 35:2 <b>repeat</b> 42:17 45:13 <b>rephrase</b> 93:25 <b>replies</b> 7:22 <b>report</b> 5:22,24 7:24 8:11,15 8:18,25 9:19 9:20,22 23:1 24:3 27:12 33:6,16,18 34:19 35:10,20 36:17 37:14,24 38:1,22 39:1 40:10 41:6,9 43:7,9 48:18 48:24 49:12,16 61:24 64:14 65:21 66:20 68:11,17 69:15 74:18 82:21 87:10 93:20 94:3,10,13 95:22 96:14,18 97:1,4 100:10 100:16,17,21 100:25 101:5 101:17 104:19 105:6,9,13,17 105:23 107:15 108:25 109:11 <b>reported</b> 1:23 35:5,13 36:12 52:23,25 65:19 65:22,24 66:4 72:11 <b>Reporter</b> 1:24	2:6 <b>reports</b> 8:4,5,7 8:21 101:21 103:11,20 105:7,14,18,20 105:23 106:4 <b>represent</b> 25:5 26:14 <b>request</b> 9:13 <b>required</b> 81:10 <b>requires</b> 96:22 <b>research</b> 79:5,9 <b>resident</b> 27:12 30:13 <b>residents</b> 26:14 26:16,17,21 27:9,11 29:3 31:6,14 <b>residual</b> 77:18 <b>resistance</b> 95:4 95:12,19 <b>resistant</b> 94:17 94:18 95:2,4,5 95:17 96:13 <b>resolve</b> 20:13,15 55:9 <b>resolved</b> 35:12 55:8,14 66:3 <b>respect</b> 41:2,3 70:25 109:8 <b>responded</b> 100:18 <b>response</b> 10:19 37:6 57:19,20 109:19 111:9 <b>responsibilities</b> 16:7 <b>rest</b> 18:25 21:1 <b>result</b> 69:8 <b>resulted</b> 85:15 <b>resulting</b> 70:3 81:15 85:7 110:22 <b>resuscitated</b> 51:23 100:8 <b>retained</b> 11:25 12:5 19:7,9 <b>retrospect</b> 53:4	<b>revealed</b> 6:3 <b>review</b> 10:1,1,2 10:2 19:22 20:5,7 22:9 24:2 92:24 96:18 103:11 104:12,14,18 104:21 109:11 <b>reviewed</b> 7:8,23 8:4,7,11 9:13 11:22 15:17,25 33:6,8,9 93:20 94:3 101:18,19 105:5,12,25 107:23 108:25 <b>REYNOLDS</b> 3:7 <b>rib</b> 39:16 <b>Richards</b> 3:13 <b>right</b> 6:14 31:18 41:1 43:4 52:6 64:20 65:25 71:10 73:3,4 75:3 87:19 94:5 108:2,7 108:11,16 110:12 <b>rights</b> 22:13,18 22:20 <b>risk</b> 50:21 58:12 59:23 60:12 73:13 75:23 81:1,8 <b>role</b> 14:5 67:1 90:14 <b>room</b> 30:7,8 31:8 54:17,25 63:8 <b>Rosanne</b> 1:23 2:5 113:4,23 <b>rotate</b> 29:21 <b>rotating</b> 31:17 <b>rotation</b> 28:19 29:14 <b>RPR/CRR</b> 1:23 2:5 <b>RPR/CSR/CRR</b> 113:4,23	<b>rude</b> 111:4 <b>Rule</b> 109:20 <b>ruled</b> 7:23 <b>Rules</b> 2:4 <b>run</b> 24:17 27:6 <b>running</b> 31:24 <b>runs</b> 53:13 <hr/> <b>S</b> <hr/> <b>S</b> 2:12 3:1 4:9,22 4:22 <b>S.C</b> 107:10 <b>salt</b> 32:22,24 <b>saturation</b> 86:14 <b>save</b> 96:9 <b>saved</b> 51:13 <b>saw</b> 33:18 42:23 43:2 70:23 <b>saying</b> 14:4 18:23 19:20 29:5,6,24 51:20 52:24 55:2 57:25 65:17 70:11 86:5 87:20 89:16 92:14 93:12 95:22 96:20 110:25 <b>says</b> 34:22 43:10 58:19 59:21 <b>scale</b> 41:18 <b>Schamber</b> 3:6 107:12 <b>schedule</b> 28:6 <b>school</b> 17:23 26:2 28:2 <b>scientist</b> 53:20 <b>scope</b> 38:19 47:17 109:16 109:19 <b>scratch</b> 104:6 <b>screen</b> 14:19 20:19 21:9 25:11 32:5 40:7 55:15 <b>scroll</b> 20:21 25:17 <b>scrolling</b> 21:18	<b>seal</b> 113:20 <b>second</b> 19:4 41:13 58:25 62:1,10 94:24 94:24 <b>secondary</b> 98:21 <b>Secondly</b> 27:2 <b>seconds</b> 60:5 <b>section</b> 43:22 <b>sections</b> 41:6 <b>see</b> 9:9 11:3 16:3 16:8 17:24 20:22 26:19 28:11,16 30:3 30:5 38:15 47:22 54:19 68:20 92:19,20 92:21,22 95:17 <b>seeing</b> 29:8 <b>seen</b> 55:17 56:23 60:1 92:8 99:21 100:9 <b>segment</b> 41:13 43:16,17,18,21 <b>seizure</b> 33:19,23 33:24 34:3 53:11 <b>selecting</b> 10:5 <b>send</b> 111:19 <b>sense</b> 12:7 63:11 <b>sent</b> 9:14 49:10 83:3 <b>sentence</b> 35:15 54:20 62:1,10 96:21 <b>separate</b> 10:6,9 <b>sepsis</b> 86:17 <b>sequence</b> 82:22 87:3 <b>serious</b> 74:20 76:17 <b>serum</b> 60:18 <b>service</b> 27:18 28:21,23 29:1 29:9 30:3,6 <b>services</b> 18:4 19:1 23:14 29:15
---	---	---	---	---

<b>set</b> 113:20	<b>significantly</b>	<b>sort</b> 19:15 28:5	<b>standard</b> 22:16	<b>stress</b> 16:17
<b>sets</b> 97:3	79:22	33:25 70:2	23:3,7 36:7	44:18 46:3
<b>setting</b> 30:11,12	<b>similar</b> 14:10	79:25 103:17	40:17 48:14	65:12
58:10 67:9	<b>simple</b> 14:7 42:4	106:12	52:8 60:16	<b>stressed</b> 88:18
90:2	<b>simply</b> 48:8	<b>sound</b> 94:18	83:19 99:13,19	88:22
<b>settings</b> 47:14	<b>single</b> 12:18	<b>sounds</b> 37:17	99:21 100:1,23	<b>stretching</b> 61:10
<b>seven</b> 7:11 97:1	13:12 15:3	90:20	104:10,18,19	<b>strike</b> 23:20 52:7
97:3 98:16	17:16 34:19,22	<b>source</b> 68:13	105:2 109:4	62:19 109:18
<b>severe</b> 91:9	34:24 59:21	69:21 77:15	<b>standards</b> 99:13	<b>strip</b> 4:16 43:6
94:17,19 95:2	75:4	<b>sources</b> 101:10	<b>standing</b> 42:13	55:18 56:3
95:5,16,22	<b>sir</b> 5:7 8:19	<b>sparing</b> 92:18	<b>start</b> 40:9 75:4	<b>strips</b> 42:16,18
96:6,13 98:4	12:24 25:11	<b>speak</b> 82:1	<b>started</b> 25:2	42:20,21,23,24
98:11	26:17 49:3	<b>speaking</b> 73:19	30:25 73:2	<b>stroke</b> 19:20
<b>severely</b> 41:20	75:3 106:25	94:7	<b>state</b> 2:7 5:7	<b>strong</b> 58:21
<b>shareholders</b>	<b>sit</b> 33:11	<b>special</b> 105:4	11:23 13:8	<b>structural</b> 63:24
107:24	<b>sixes</b> 97:7,8	<b>specialty</b> 5:12	15:3 22:4,10	<b>structure</b> 108:5
<b>sharing</b> 11:7	<b>slides</b> 30:18	<b>specific</b> 35:8	26:1 33:6	108:13
61:21	<b>sloppy</b> 93:11	102:13	41:22 66:20,23	<b>students</b> 26:9,21
<b>Shasta</b> 3:11	<b>small</b> 12:10,15	<b>specifically</b>	83:9,14 106:9	27:4 31:14,16
<b>Sheriff's</b> 3:11	90:7,8 95:24	94:21	112:2 113:1,5	<b>subject</b> 106:12
<b>shocked</b> 60:3,10	<b>smaller</b> 20:16	<b>specificity</b>	114:1	<b>substantial</b>
<b>shop</b> 71:18	<b>smoke</b> 78:17	110:23	<b>statement</b> 46:20	60:12 66:21
<b>short</b> 39:18	<b>smoker</b> 75:18	<b>speed</b> 60:4	62:21 93:1	81:1
89:23	78:14	<b>spend</b> 106:3	<b>states</b> 1:1 15:16	<b>sudden</b> 81:1
<b>short-term</b>	<b>smokers</b> 76:10	<b>spent</b> 103:2,23	15:18,23 16:1	<b>suffered</b> 100:19
71:23	76:11	104:2 105:20	44:18 46:3	<b>suffering</b> 37:8
<b>shorten</b> 107:17	<b>smoking</b> 75:25	<b>spewing</b> 39:4	72:24 88:18	52:18
<b>shorter</b> 53:13	78:16 79:7	<b>spiral</b> 85:6,14	112:2	<b>sufficient</b> 44:23
<b>shortness</b> 39:12	<b>somebody</b> 35:17	90:14,16	<b>stating</b> 45:7 52:7	<b>sufficiently</b> 67:4
42:7 46:6,19	39:16 48:1	<b>spiro lactone</b>	<b>status</b> 108:6	<b>suggest</b> 84:2
47:1,8,10 51:6	58:13	92:17	<b>steady</b> 41:22	<b>suggested</b> 99:8
52:2 61:17,19	<b>somebody's</b> 42:6	<b>spoke</b> 31:13	<b>STENOGRAPHA...</b>	<b>suggestive</b> 44:8
63:2,19 72:13	<b>someone's</b> 58:3	97:18	61:8 75:12	44:9
74:12 85:6,15	86:15 89:21	<b>spontaneously</b>	103:4	<b>Suite</b> 2:18 3:3,8
90:2 92:9	<b>something's</b>	27:9	<b>Stenographica...</b>	<b>Summary</b> 94:25
110:8	32:25	<b>squeezed</b> 91:18	1:23	<b>Sunday</b> 65:20
<b>show</b> 34:11	<b>somewhat</b> 76:11	<b>SS</b> 113:1 114:2	<b>step</b> 40:7	<b>superimposed</b>
62:24 92:6	<b>sorry</b> 8:11,14	<b>St</b> 3:3 43:17,21	<b>steps</b> 73:15	49:24 50:7
<b>showed</b> 62:23	14:16 18:19	43:25 45:2	<b>stiffen</b> 90:1	<b>supervise</b> 26:17
<b>showing</b> 34:8	25:1 29:10	55:3,6,7	<b>stood</b> 21:2	<b>supplement</b>
44:5,14	37:3 39:22	<b>stabilizing</b> 48:14	<b>stop</b> 48:17 60:2	80:17
<b>shown</b> 9:11 68:1	42:17,21 45:13	<b>staff</b> 27:3 84:22	94:20	<b>supplements</b>
<b>shows</b> 56:3	61:8 62:4 65:1	100:17	<b>straightforward</b>	80:20,21
<b>side</b> 19:22	70:21 75:12	<b>Staffing</b> 1:14 3:5	49:5	<b>supplied</b> 93:8
<b>significance</b>	80:5 91:2,13	107:10	<b>strange</b> 94:16	<b>supply</b> 46:1 65:4
42:1,9	94:20 101:14	<b>Stan</b> 3:11	<b>street</b> 2:14 3:3,8	65:14 88:16,24
<b>significant</b> 25:13	105:10 106:17	<b>stand</b> 20:22	6:8 77:8	89:11,12
67:2 96:7 98:6	106:22 109:12	101:4	<b>streets</b> 80:24	<b>supportive</b>

100:22	<b>tables</b> 71:1,5	<b>terrible</b> 77:12	26:24 39:4	<b>tick</b> 76:15
<b>sure</b> 8:15,17	72:19,24 73:3	<b>territory</b> 44:7	48:13,18,19	<b>tighten</b> 65:14
11:21 12:3,6	76:19	<b>test</b> 39:25	51:25 57:8	90:7
12:13 13:2,6	<b>tachycardia</b>	<b>testified</b> 5:4 7:7	75:8 78:4,13	<b>tilted</b> 19:15
14:17 15:13	56:10 58:1,3	7:10,14,20	79:9 84:19	<b>time</b> 7:24 12:25
25:9 26:12	63:1 66:6,11	10:22 11:16	89:18 105:22	15:8 16:4,13
55:10 62:5	<b>tail</b> 15:13	12:24 13:21	<b>think</b> 6:13 8:15	16:22,23 19:24
65:18 70:5,11	<b>take</b> 10:14 39:21	14:25 15:2,15	11:20 12:4	24:25 26:15,18
70:18 84:4,12	51:1 55:13	15:18,22 19:6	13:2,5 14:1,9	30:10 33:10
97:15,16,17,20	71:14 84:2,7	20:23 21:14	15:12 19:23	35:3 39:16
97:23 107:20	94:8,11 107:5	22:1,4	22:5 27:13	65:3 66:7,11
<b>surgeries</b> 36:23	111:10 112:7	<b>testify</b> 7:5 11:13	29:25 30:13	66:14 70:15
37:10 81:14	<b>taken</b> 2:3 35:9	11:17 20:9,12	36:4 40:10	88:15 89:19
<b>survival</b> 74:2,8	40:3 84:13	20:14 22:23	41:1 47:18	96:9 103:23
79:8	92:20 113:11	<b>testifying</b> 19:12	48:21 49:5,17	104:2,17
<b>survived</b> 40:22	114:9	20:16 23:2	52:6,15 55:21	105:21 106:4
59:11 63:8	<b>talk</b> 73:21 82:9	110:14	63:20,25 64:6	110:21
64:11 81:5	108:14	<b>testimonial</b> 19:3	65:6,7 67:2,11	<b>timeline</b> 33:16
83:5	<b>talked</b> 22:21	<b>testimony</b> 7:4	67:14 69:16	<b>timely</b> 83:4
<b>sustained</b> 68:2,5	49:16 84:19	10:17,19,19	72:20,22 78:13	99:17
68:8 72:16	<b>talking</b> 93:9	11:10,12 13:7	78:17,18 80:24	<b>times</b> 6:20 7:7
<b>sworn</b> 5:3	<b>talks</b> 31:5,10	14:20 15:14	81:3,4 82:18	7:11,13 11:16
<b>symptom</b> 47:19	<b>Taxman</b> 13:18	20:19 21:10	85:8 86:5,12	27:2,8 100:5
72:16	<b>teach</b> 26:9,24	34:19 35:11	87:4,6 88:3	<b>title</b> 26:12
<b>Symptomatic</b>	27:20	52:21 85:1	94:11,16 95:25	<b>tobacco</b> 79:1
69:13	<b>team</b> 26:20 27:6	104:22	96:2,22 97:8	<b>today</b> 5:14 9:14
<b>symptoms</b> 35:9	27:19 31:9	<b>testing</b> 16:17	98:24,25 106:6	33:11 93:20,22
35:21 41:25	<b>technically</b>	<b>thank</b> 24:22	107:3,6 109:14	<b>today's</b> 106:16
42:2 46:7 47:6	93:13 98:23	25:9 55:25	110:5,21,25	<b>told</b> 29:18
47:7 50:21	<b>tecum</b> 9:13	84:1,11,24	111:5 112:4	107:14
53:15 65:19,23	10:20	91:4 103:7	<b>thinking</b> 47:5	<b>tolerable</b> 50:15
65:24,25 66:4	<b>tell</b> 8:6 9:4 16:6	106:24 108:22	<b>third</b> 62:1,4,6	<b>tolerated</b> 50:14
92:5,7	17:24 19:21	111:14,17	<b>thought</b> 83:7,8	<b>tools</b> 48:2
<b>syndrome</b> 77:10	21:4 41:11	112:7	84:25 110:21	<b>top</b> 42:24 90:11
<b>system</b> 69:14	58:23 67:19	<b>thanks</b> 40:2	111:4	<b>torsades</b> 55:21
<b>systemic</b> 90:17	73:12 76:16	<b>theoretic</b> 71:16	<b>threat</b> 82:16	56:4,5,5,6,7,15
	90:15	<b>theoretically</b>	<b>threatening</b>	56:24 57:1,4,7
<b>T</b>	<b>telling</b> 73:15	51:3	75:10	57:20,21 58:8
<b>T</b> 4:9,22 5:5	<b>tells</b> 33:21	<b>theory</b> 35:3 47:3	<b>three</b> 22:5,8	58:17,20,23,24
84:15 107:1	<b>ten</b> 13:2 84:5	47:9 61:20	27:2 35:17	59:25 60:2,6,8
108:23	<b>tend</b> 55:9	67:7	57:21,22 71:16	60:10 81:5
<b>T-O-R-S-A-D-...</b>	<b>tends</b> 45:3	<b>thin</b> 38:10 39:7	81:14,19 91:10	87:16
56:5	<b>term</b> 65:2 93:13	<b>thing</b> 39:14,22	96:8 98:11	<b>totally</b> 75:1
<b>T-wave</b> 43:18	94:16	51:9 72:5	111:19	85:20
<b>T-waves</b> 44:4	<b>terms</b> 6:4 49:7	86:23 94:10	<b>threshold</b> 57:3	<b>town</b> 104:15
<b>table</b> 73:9,10,21	55:1 59:12,23	95:21 112:1	<b>throw</b> 95:21	<b>toxicity</b> 60:1
73:22 75:4	68:7 87:5 91:8	<b>things</b> 9:16	<b>throwing</b> 85:17	<b>track</b> 12:22
76:22	91:10 93:6	17:20 23:25	<b>thrust</b> 100:4	50:11

<b>traditionally</b> 45:24 65:6	52:10 59:5 64:4,14,21	<b>understanding</b> 17:7 22:22	58:2,16,17,19 58:22,25 59:11	<b>vulnerability</b> 98:14
<b>trained</b> 23:16	74:19 77:9	49:20 69:21	60:2 63:25	
<b>training</b> 26:11	89:11	72:25 73:1	66:18,22 98:2	<b>W</b>
27:4,19	<b>Tuesday</b> 1:18	87:19 89:2,10	<b>V3</b> 44:3	<b>W9</b> 111:23
<b>transcribed</b> 7:20	<b>tumor</b> 80:15	92:3 94:2	<b>V6</b> 44:3	<b>wading</b> 18:19
<b>transcript</b> 4:18	<b>turn</b> 38:1	103:16,20	<b>vague</b> 47:18	<b>waiting</b> 14:12
5:1 112:12	<b>turned</b> 31:20	111:2	82:6	<b>waive</b> 111:25
114:8	<b>turning</b> 40:9	<b>understood</b>	<b>valve</b> 32:25	112:3
<b>transcripts</b>	<b>two</b> 10:19 13:17	57:16,19 84:25	<b>variance</b> 96:1	<b>walking</b> 80:24
107:23	27:16 36:18	87:9 93:19	<b>varies</b> 94:13	<b>wall</b> 88:2
<b>transferred</b>	57:21 86:13	101:22	<b>vary</b> 82:3	<b>want</b> 19:3 20:7
40:22	96:6 97:7,8	<b>unified</b> 90:22	<b>Vasotec</b> 70:14	27:14 36:6
<b>transient</b> 45:2	98:3	<b>unintelligible</b>	70:20	48:12 54:10,14
63:24	<b>two-three</b> 57:6	75:11	<b>vast</b> 82:18	61:24 65:18,25
<b>transplant</b> 71:25	<b>type</b> 59:17	<b>unit</b> 30:25 31:1	<b>ventricle</b> 44:10	74:19 76:15,15
<b>travel</b> 104:16	<b>types</b> 6:18 46:7	<b>UNITED</b> 1:1	50:16 74:10	84:18 86:1
<b>Travis</b> 3:6	<b>typical</b> 103:19	<b>unknown</b> 91:1,3	87:13,23 89:22	97:15,15 100:3
<b>treat</b> 81:12	<b>U</b>	<b>Unquestionably</b>	90:1,10 92:23	111:4
<b>treatable</b> 80:13	U 4:22	58:20	<b>ventricular</b> 56:9	<b>wanted</b> 73:5
<b>treated</b> 74:11	<b>ultimate</b> 98:3	<b>unsure</b> 21:2	58:1,3 63:1	<b>wanting</b> 38:2
<b>treatment</b> 70:4	<b>ultimately</b> 86:22	<b>unusual</b> 38:21	66:6,10 67:5	<b>warehouse</b>
<b>trial</b> 4:14 5:20	<b>unacceptable</b>	<b>upcoming</b>	68:2,7,8 96:3	31:22
7:12 10:17	59:19	103:11	98:3,22	<b>Warren</b> 3:11
14:20 15:19,20	<b>undercapitaliz...</b>	<b>updated</b> 25:18	<b>venues</b> 27:20	<b>wasn't</b> 25:1,9
19:6 20:18,19	108:11	<b>updates</b> 25:13	<b>versus</b> 66:24	34:10,13 46:1
20:24 104:14	<b>underinsured</b>	<b>ups</b> 50:10	76:18	51:2 52:9
104:22	108:10	<b>urgent</b> 67:10	<b>vessel</b> 90:8	59:25 60:5,7,9
<b>trials</b> 7:15,17	<b>underlying</b>	<b>urinary</b> 79:11	<b>vessels</b> 90:7	72:15 74:11
<b>trigger</b> 12:10	63:23 74:21	<b>USA</b> 1:14 3:5	<b>video</b> 9:3 33:12	77:8,22 78:8
13:25 67:15,16	75:6 87:11	107:10,25	33:14,19 34:2	80:15 92:16,18
67:17	90:24 99:2	108:6	53:12	95:10,13 98:9
<b>triggered</b> 67:5	110:7	<b>use</b> 30:19 64:2	<b>view</b> 32:20	<b>waste</b> 19:24
86:21 87:18	<b>understand</b> 5:18	65:1,2 67:19	<b>viewpoint</b> 73:14	<b>wasting</b> 69:22
88:5 96:5	18:20 23:6	69:14 73:7	<b>violations</b> 22:20	70:12
<b>true</b> 34:18 39:5	29:6 36:11	91:10 93:6	<b>Virtually</b> 11:14	<b>waves</b> 45:4
56:15 61:18	49:22 52:10,12	95:3	<b>visit</b> 47:21 72:12	<b>way</b> 12:22 19:15
114:10	52:16 53:20,24	<b>usually</b> 29:19	<b>visits</b> 78:10	20:15 25:1
<b>truth</b> 104:1	54:1 64:6,15	30:6 45:1 47:4	92:10	29:17 31:11
<b>try</b> 21:16 28:10	64:21 65:18	61:13 69:8,11	<b>vitae</b> 4:11 6:7	34:7 45:23
59:17 89:19	70:11 72:23	72:20 73:11,16	10:13 25:12	66:18 67:1
97:19 104:24	77:2 85:25	89:18 93:8,18	<b>vitals</b> 41:12 68:1	72:9 80:20
<b>trying</b> 5:18	88:7 89:11	<b>utility</b> 58:18	<b>volume</b> 92:21	91:8 98:8
14:14 24:23	92:11 94:5	<b>V</b>	<b>voluntary</b> 17:8	109:22
26:7 31:11	100:24 110:19	<b>V-fib</b> 98:2	26:3	<b>ways</b> 65:10
48:7,11,12	<b>understandable</b>	<b>V-tach</b> 53:13	<b>volunteered</b>	86:13
49:3,18,18,22	89:15	56:12 57:7,8	35:16	<b>we'll</b> 23:8 40:10
50:3,9 52:10			<b>vs</b> 1:6,13	48:25 55:15

84:7	111:15,18,23	37:2 42:19	105:8	1987 6:19
<b>we're</b> 29:11	111:25 112:6	43:2 45:4	<b>1,000</b> 7:8	<b>1991</b> 31:2
32:19 48:7	113:19	48:11,11,21	<b>1,100</b> 7:8	
96:1 99:4	<b>Wolff</b> 8:9,10,11	54:3,19 61:19	<b>1:05</b> 1:19 2:10	<b>2</b>
<b>weaken</b> 38:9	8:14,14 33:23	74:7 77:2	112:8	<b>2</b> 5:23 32:6
<b>weakened</b> 50:15	49:6 93:20,21	99:17 100:22	<b>1:15</b> 84:9	36:17 101:17
<b>wealthier</b> 18:14	94:3,8 97:3	104:8 108:21	<b>1:25</b> 84:10	105:9
<b>website</b> 17:5	100:11	109:8	<b>10</b> 4:11,12,13,14	<b>2.3</b> 60:11,19,21
31:25	<b>Wolff's</b> 8:18,25	<b>year</b> 6:23 7:1,1	7:1,13 16:23	67:4
<b>Wednesday</b>	96:14 97:21	7:12,13 15:11	113:24	<b>2.6</b> 60:20,23
102:25 103:9	<b>word</b> 12:18	27:2,8 29:20	<b>10-minute</b> 84:3	61:2
<b>week</b> 17:25 18:1	13:12 69:14,16	30:17 37:15,21	84:7	<b>20</b> 24:18,20
<b>weigh</b> 76:9	<b>work</b> 9:17 88:11	38:9,22 71:6,6	<b>10:04</b> 1:19 2:9	30:24 31:2
<b>weighed</b> 40:19	90:9 102:1,7	73:17 104:7	113:13	32:24 76:10
<b>weighing</b> 75:22	103:2,17	<b>years</b> 6:19,21,25	<b>100</b> 13:6 14:17	<b>20-CV-1123</b> 1:6
76:25	104:11 105:1	7:3,9,9,12	26:12 44:8	<b>2000s</b> 24:19
<b>weird</b> 25:23 26:7	<b>worked</b> 13:14,17	10:23 13:2	55:10 60:20	<b>2006</b> 31:3
<b>welcome</b> 25:10	<b>works</b> 33:4	15:3 20:20	69:9 86:15	<b>2011</b> 70:23
111:18	48:22	24:19 25:14,20	<b>107</b> 4:5	<b>2017</b> 95:9
<b>well-known</b>	<b>workup</b> 80:11	27:16 28:15,18	<b>108</b> 4:3	<b>2019</b> 33:7 71:6
19:22	81:6	28:24 30:24	<b>11</b> 7:1,13	92:7
<b>went</b> 14:24 31:4	<b>world</b> 64:3	31:2 32:13	<b>11:00</b> 40:3	<b>2021</b> 11:12,13
35:7 40:16	<b>worse</b> 32:23	70:24 71:15	<b>11:07</b> 40:4	11:17 15:9,11
60:19 63:16	59:22 95:9	72:2,22,22	<b>110</b> 69:9	<b>2022</b> 11:17
78:9 81:25	<b>wouldn't</b> 14:7	95:8	<b>117</b> 4:11 10:14	25:15
82:9 104:7,9	21:4 29:12,17	<b>Yesterday</b> 9:3	25:13 112:9	<b>2023</b> 104:9
<b>weren't</b> 75:10	34:11 48:9	<b>York</b> 1:20,20	<b>118</b> 4:12 10:16	<b>2024</b> 5:23 7:25
<b>Wesley</b> 3:6	59:16 73:24	2:8,8 8:13	102:22	30:15,16
<b>WESTERN</b> 1:2	<b>wrap</b> 83:6	16:20 22:3,10	<b>119</b> 4:13 10:16	<b>2025</b> 1:18 2:9
<b>whereof</b> 113:19	<b>write</b> 10:9	26:1 31:22	11:8 21:11	102:23 103:3
<b>whiteboard</b>	<b>writing</b> 47:7	106:7,10,13	<b>12-lead</b> 55:3	113:12,21
30:19	104:19 113:8	113:11,12	62:25	114:9,17
<b>willing</b> 20:12	<b>written</b> 94:3	114:9,10	<b>12/22/19</b> 62:14	<b>2026</b> 29:22
<b>Wisconsin</b> 1:2	96:14 102:4,11	<b>young</b> 8:13	<b>12:15</b> 84:13	113:24
2:7,18 3:9	102:16	37:11 108:1	<b>12:25</b> 84:7,14	<b>219</b> 2:18
11:23 113:1,6	<b>wrong</b> 7:20	109:8	<b>120</b> 4:14 10:17	<b>21st</b> 83:12
114:1	89:16	<b>Young's</b> 8:21	14:19	<b>22</b> 45:19 52:19
<b>wish</b> 109:10	<b>wrote</b> 55:20	24:3 109:11	<b>121</b> 4:15 54:11	65:20 76:10
<b>withdrawal</b> 51:3			<b>122</b> 4:16 55:16	<b>22-CV-723</b> 1:13
82:21,24 83:11	<b>X</b>	<b>Z</b>	112:9	<b>22nd</b> 45:11 53:8
83:16	<b>X</b> 4:1,9 5:5	<b>zero</b> 71:18	<b>1339</b> 4:15	54:5 83:12
<b>withdrawing</b>	84:15 107:1	<b>Zoom</b> 1:17 2:1	<b>142</b> 42:1,8,10	102:23 103:3,9
83:1 90:12	108:23	2:16,20 3:5,10	<b>15</b> 15:19 16:23	<b>23</b> 33:7 54:18
<b>witness</b> 2:2 40:1	<b>Y</b>	<b>0</b>	16:23 19:11,17	<b>23rd</b> 83:12 85:3
53:21 54:19	<b>yeah</b> 7:17 11:20	<b>1</b>	20:4,10 24:18	<b>24th</b> 59:1
83:25 84:9,11	14:14 25:5		<b>1559</b> 4:16	<b>25</b> 16:9,12 24:20
104:11 106:25	29:12 31:11	<b>1</b> 98:1 101:17	<b>17</b> 11:16	<b>2750</b> 3:3
108:19 109:18			<b>180758</b> 1:23	<b>28th</b> 1:18 2:8

113:12 114:9	61:24 62:5,6	<b>9</b>		
<b>3</b>	67:19 98:18	<b>9:00</b> 16:21		
<b>3</b> 33:18 41:8	99:4	<b>900</b> 7:6,19		
59:22,22 67:25	<b>5,000</b> 104:22	<b>90s</b> 71:21		
68:1 80:25	<b>5:00</b> 16:21	<b>92</b> 42:1,8,10		
94:24 100:17	<b>50</b> 91:16	<b>95</b> 19:12		
<b>3.0</b> 59:13	<b>53202</b> 2:18 3:9	<b>96</b> 19:12		
<b>3.5</b> 59:18	<b>54</b> 4:15			
<b>3:00</b> 65:20 66:4	<b>55</b> 4:16			
<b>30</b> 3:3 32:13	<b>550</b> 104:6,19,21			
109:20	<b>55101-1812</b> 3:3			
<b>301</b> 3:8	<b>6</b>			
<b>31.3</b> 73:17,17	<b>6</b> 99:5,10			
<b>311</b> 2:14	<b>6-</b> 7:16			
<b>312-243-5900</b>	<b>6,000</b> 104:15			
2:15	<b>6:00</b> 27:10			
<b>35</b> 91:14,19	<b>60</b> 18:1 91:17,17			
<b>360</b> 6:22	<b>600</b> 104:7,9,10			
<b>360-plus</b> 6:20	104:21			
<b>37</b> 7:9	<b>60607</b> 2:14			
<b>370</b> 7:2	<b>63rd</b> 6:8			
<b>38</b> 6:19 7:8,12	<b>651-291-1177</b>			
<b>3rd</b> 2:14 113:21	3:4			
<b>4</b>	<b>7</b>			
<b>4</b> 19:13 42:24	<b>7</b> 20:11 97:7,9			
43:13 59:18	99:11 100:15			
98:17	<b>7:00</b> 52:19,25			
<b>40</b> 15:16,18 16:1	<b>7:30</b> 34:20			
18:1 70:22	<b>70</b> 91:16			
71:15 72:22	<b>700</b> 7:16 104:12			
91:12,14,19	<b>710</b> 2:18			
<b>40-year-olds</b>	<b>7th</b> 3:3			
71:16 76:11	<b>8</b>			
<b>400</b> 3:8	<b>8</b> 74:18 97:10			
<b>41</b> 71:23 75:24	100:15			
<b>41-year-old</b> 72:3	<b>8:00</b> 35:12 36:13			
<b>41-year-olds</b>	36:16 52:19,25			
71:14,17	<b>8:00-something</b>			
<b>414-276-2108</b>	35:25			
2:19	<b>8:53</b> 41:12			
<b>414-455-7676</b>	<b>80s</b> 71:21			
3:9	<b>81</b> 71:15,20			
<b>45</b> 72:22 91:13	<b>84</b> 4:4			
<b>5</b>	<b>85</b> 16:22 19:10			
<b>5</b> 4:3 19:13				